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ABSTRACT

Although family planning clinics receiving some form of federal support constitute the major source of birth control for teenagers, they are not reaching large numbers of sexually active teens nor are they reaching them soon enough--especially those who are 14 and younger. In many cases they also fail to promote effective contraceptive use among those teens they do reach. Three "threshold" conditions exist which a clinic must meet in order to attract teens in the first place: (1) it must make sure teens know it is available to them; (2) it must guarantee confidentiality and anonymity; and (3) it must be affordable. Once these three conditions are met, other secondary factors influence teens to make an initial visit: location, ease of transportation, convenience of clinic hours, length of appointment wait, and ease of admission. Until a clinic meets the three threshold conditions, however, it will not attract large numbers of teenagers--unless it is in fact (or is perceived by teens to be) the only clinic available to them. These are among the findings of a survey on teenagers' use of contraception and other family planning services. A detailed description of the method of the study, as well as more information about its results, are given in the final report. A condensed version, including recommendations for action by the federal government, is given in the accompanying Executive Summary. (Author/BPT)

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IMPROVING FAMILY PLANNING SERVICES FOR TEENAGERS

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
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EXECUTIVE SUMMARY

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IMPROVING FAMILY PLANNING SERVICES FOR TEENAGERS

EXECUTIVE SUMMARY

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The views articulated in this report are those of URSA, and do not necessarily reflect those of the Department of Health, Education, and Welfare.

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In addition, we wish to extend our special appreciation to Clara Schiffer of the Department of Health, Education and Welfare. Ms. Schiffer was responsible for conceiving the idea of the study and for the development of the project.

As the Project Officer, her continual assistance and support were invaluable. Her concern for the improvement of health services and the problems of adolescents was an inspiration to the team throughout the study.

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CHAPTER 1. INTRODUCTION

1.1 Rationale

There is a broad unanimity of opinion among experts in the field that teenagers in the U.S. population are becoming sexually active at younger ages; for example, J.G. Dryfoos has estimated that the proportion of sexually active unmarried girls aged 15 to 19 has increased from 28% in 1971 to 36% in 1973, or from 2.35 million to 3.34 million. At the same time, birth rates among the very young teenagers are increasing during a period when birth rates for all other age groups in the population are declining. Thus births to teenage mothers are becoming an ever-larger proportion of all births. Between 1963 and 1973, the number of births per 1,000 women increased from four to six at age 14, from 12 to 16 at age 15, and from 32 to 37 at age 16.

Moreover, abortion statistics indicate that many of the births to teenage mothers are unplanned and unwanted. Teenagers comprise only one-fifth of the population of females of reproductive age, yet in 1974, they accounted for one-third of the reported number of legal abortions. Women in the 15 to 19 year old group have a high ratio of abortions to live births, but young women under age 15 have the highest ratio of abortions to live births of any age group in the population.

Pregnancy, particularly an out-of-wedlock pregnancy, often means the end of formal education for the school age girl. Even in those instances where teenage couples attempt to legitimate an out-of-wedlock conception by marriage, the research indicates that there is a higher than average chance that they will remain economically disadvantaged throughout their lives. That this practice is widespread is indicated by the findings of the National Natality Study, 1964-1966, which disclosed that 42% of the first births to married females occurred less than eight months after marriage.

The social and economic consequences of unwanted pregnancies and out-of-wedlock births are not the only problems associated with uninformed and unprotected sexual activities among teenagers, however. There are serious psychological and physical consequences as well--and, these consequences are suffered by both mother and child in many instances--or even by subsequent children.

Dr. Nicholas Wright of the Population Council has identified a variety of risks associated with teenage pregnancies, including:

- Higher maternal mortality rates for white mothers under 20. Mortality rates are about 30% higher than for mothers in the next higher age group (20-24 years). Deaths due to toxemia are 50% higher for both white and non-white teenagers than for women 20-24 years of age.

- Ratios of fetal deaths late in pregnancy are 15% higher among women under 20 than among 20 to 24 year old women, and the risk increases rapidly as parity increases.

- There is a 30% higher risk of infant mortality among children born to teenage mothers than those with mothers in the 20 to 24 year old range. In addition, there is an even greater differential risk to other live-born children subsequently delivered by teenage mothers.

- Children born to mothers aged 15 to 19 are 36% more likely to be premature (as measured by weight) than the offspring of 20 to 24 year old women. The differential risk is even greater for mothers under 15.

- Teenagers who are unintentionally pregnant tend to delay the decision to obtain an abortion for a longer period than older women in comparable circumstances, and thus, suffer a higher risk of complications.

In a related set of findings, Dr. Rosalind Ting, of the Philadelphia Collaborative Perinatal Study, concluded that very young mothers (those who bear their first child at 15 years or younger) are more than three times as likely to have three or more additional children in the next seven years than are ethnically and socio-economically comparable women between the ages of 20 and 24.

Thus, to summarize, women who begin bearing children during their teenage years have more children; are considerably more likely to lose their children through miscarriage, late fetal death or stillbirth; give birth to premature children; lose those live-born children they do have before their first birthday; and run the risk of much higher rates of maternal death due to complications related to pregnancy or birth.

In addition to the serious threats that adolescent pregnancy represent to the health of the teenage mother, her child, and subsequent children, there are other potential social costs as well. Pregnancy is reputedly the number one cause for dropping out of school among females, and a recent study has estimated that teenage mothers have a suicide rate many times higher than the general population. Finally, adolescent mothers contribute to increased welfare dependency, and in many cases carry the poverty of their own childhoods into another generation.

Thus, the failure or the inability of teenagers to obtain effective family planning services is not only a problem for sexually active teenagers and their families--it is a public problem as well, and it requires decisive public action.

Yet teenagers are receiving a disproportionately small share of publicly-funded family planning services. Although there were almost 5,000 publicly-funded family planning clinic service sites in 1974 that reported serving 3,281,517 women, only 959,118 were teenagers age 15 to 19. That is, while teenagers (15 to 19) made up 42% of the total women in need of publicly-supported services, they accounted for only 29% of the women who actually received services. In addition, while 40% of the adult "women in need" received services, only 23% of the teenage "women in need" were served.

In June 1974, official concern about the extent of unmet need for family planning services among teenagers led the U.S. Department of Health, Education and Welfare (DHEW) to contract with Urban and Rural Systems Associates (URSA) of San Francisco, California, to conduct an evaluation of family planning services for persons under age 18. The objectives of the study were:

1. To obtain data on the accessibility and provision of family planning services to persons under age 18 in a variety of delivery settings (other than offices of private physicians), but with particular emphasis on programs funded directly by DHEW.

2. To analyze the information obtained for elements of good and poor service accessibility and delivery.

3. To make recommendations for improved accessibility and quality of services to the young patient in DHEW-funded programs.

4. To prepare information for dissemination to both DHEW-funded and other programs about successful services for the young patient.

The results of the study are discussed fully in a report entitled "Improving Family Planning Services for Teenagers." This Executive Summary is intended to summarize the major findings of the study and the recommendations set forth in the report.

1.2 Field Methodology

The URSA research team was comprised of family planning professionals with experience in the administration and operation of teen clinics. In carrying out the study, the research team made on-site visits to 40 clinics in eight metropolitan areas and five rural areas located in eight separate states. The clinics in the study were sponsored by a variety of different kinds of providers: five were sponsored by county hospitals, four were sponsored by other hospitals--primarily private hospitals, 11 clinics were sponsored by city or county health departments, ten by Planned Parenthood affiliates, six clinics were sponsored by other types of single-purpose family planning agencies, and four clinics were sponsored by various multi-purpose agencies such as neighborhood health centers, "free" clinics, social service agencies like Y's or adolescent centers, and women's health clinics.

Prior to the on-site visits, the URSA team conducted an extensive review of the literature, collected basic information on the communities served by the providers selected for inclusion in the study, and asked the administrators of participating clinics to complete structured questionnaires designed to collect data about the program's size, budget, structure, staffing, range of services provided, and number of patients served.

During the on-site visits, the URSA team carried out several activities:

- They asked teenage patients to complete self-administered questionnaires designed to collect demographic data and information about their assessment of various aspects of the clinic experience. Questionnaires were filled out by 423 teenage patients.

- They interviewed teenage patients--usually at the end of the clinic visit--to obtain further insights into the teenagers' feelings

about the services provided by the clinic, the motivational factors leading to clinic utilization, the sources of information they used in determining which clinic to attend, and the extent of their knowledge about other available services in the area. A total of 105 teenagers agreed to be interviewed.

- They observed clinic operations, and in 36 of the 40 clinics, the URSA team accompanied one or more teenage patients through all of the various clinic procedures.

- They asked males who had come to the clinic with teenage women patients to complete questionnaires designed to obtain demographic data, information about their reactions to the clinic, and data on their involvement in the utilization of contraception. A total of 46 questionnaires were filled out by male respondents at 23 of the 40 clinic sites.

- They also interviewed "non-user" teenagers--those enrolled in prenatal services and/or special school programs for pregnant students--and asked them to fill out questionnaires. The questionnaires were similar to those used with teenage family planning patients, but they were modified to make them appropriate for use with pregnant adolescents or those in postpartum programs. Data collection activities with pregnant or postpartum teenagers were aimed at obtaining demographic information, data about clinic preferences, insight into the extent of their knowledge about the availability of family planning services in the community, and their reactions to and past experiences with family planning programs. "Non-user" teenagers completed a total of 118 questionnaires in seven of the eight metropolitan study areas. In addition, group or individual interviews were conducted with approximately 60 of the teenagers who completed questionnaires.

CHAPTER 2. FINDINGS

The URSA research team's efforts were focused on three major areas of inquiry:

1. Identification of the factors that either diminish or enhance a provider's effectiveness in reaching teens and getting them into a family planning clinic--that is, in facilitating teenagers' "initial access" to an organized family planning program.

2. Identification of the factors that either diminish or enhance a provider's ability to keep teenage patients enrolled in the program and willing to return for check-ups, contraceptive supplies, annual re-visits, or to discuss complications--that is, a provider's ability to facilitate "continuing access" on the part of the teenage patient.

3. Identification of the factors that either diminish or enhance a provider's ability to help teenagers choose an appropriate birth control method and to use it competently--that is, in promoting "contraceptor effectiveness."

In addition, as the study proceeded, the URSA research team also became aware of the need to include an assessment of the quality of services and medical care provided to teenagers--particularly those services specifically related to the prescription and use of contraceptives.

2.1 Initial Access

As the statistics cited earlier indicate, teenagers do not have equal access to publicly-supported family planning services. They are underserved compared to the overall population of women in need. It also seems that many of those teenagers who are being served were at serious risk for extended periods before they received services. Ninety percent of the teenagers interviewed by URSA had been sexually active before coming to the clinic the first time and fully 75% had been having intercourse for at least a year or more before coming to the clinic. Twenty-seven percent of them had had a prior pregnancy. Thus, even in those cases where organized family planning programs are reaching teenagers, they are not being reached early enough to prevent what must be considered an unacceptable degree of risk, and--in most instances--they are not being reached in numbers proportionate to their representation in the population of sexually active women.

URSA's findings indicate that before large numbers of teenagers will utilize a family planning program, they must feel that the program is available, confidential, and affordable.

To be considered available by teenagers, a program must meet two conditions. First, it must be perceived as a program that is geared to their need for birth control services. Second, adolescents must believe that the program is open to their participation without inhibiting eligibility restrictions such as minimum or maximum age levels, or parental consent--they must feel that teenagers are welcomed as patients.

In several cases when teenagers were asked why they did not utilize other clinics in the community, they indicated that the other clinics had special eligibility requirements--they only served married women, or did not serve teenagers, etc. Often they were wrong--the other programs were in fact open to teenagers, but they had failed to make that explicit and teenage patients did not feel that they would be welcome. This availability must be perceived by the teenagers--it is not sufficient for the program to just be there.

To be considered confidential, the teenagers must feel that their decision to seek contraceptive services will not be made known to their parents, other influential adults in their lives, or to their peers. The single most important deterrent to clinic use mentioned by teenagers was "fear of parents finding out." In addition, 56% of the teenagers also rated confidentiality as a "very important" feature of a clinic's services.

The extent to which teenagers perceive a program as providing for confidentiality also seems to be related to two factors--clinic location, and various clinic procedures. Teenagers--particularly the younger teenagers--do not want their non-sexually active peers, their parents, or other adults, to see them enroute to or entering a family planning clinic. Therefore, they prefer clinics that are located in places where they are not highly visible. Teenagers also frequently voiced appreciation of special precautions that clinics took to protect confidentiality, and when asked what clinics could do to make it easier to use their services, the most frequent suggestion was "let kids know that it's confidential."

Interestingly, confidentiality was valued both by teenagers who did not have parental consent and feared that their parents would be upset if they found out, and teenagers whose parents were aware that they are sexually active. As one teenager said, "My parents know that I use birth control, but I don't want to keep reminding them."

To be considered affordable, teenagers must know that the clinic is either free or that the cost of the service is reasonable. Responses to the teenage patient questionnaire indicated that two-thirds of the teenage patients rated cost of services as a "very important" feature of the program and ranked it fourth in overall importance among twelve program elements. In at least two cases teenagers who were interviewed had traveled over an hour by public transportation to reach a clinic that provided free care rather than use clinics that were closer to their homes but charged fees. Finally, the number of teenagers who cited "money problems" as an obstacle to obtaining services was directly proportionate to the amount of the fees that a clinic charged.

Availability, confidentiality, and affordability seem to function as "threshold conditions." That is, if teenagers know that a program's services are available to them without parental consent and at a reasonable cost they will utilize programs that are otherwise inconvenient or that have features that they perceive to be negative. However, access and utilization by teenagers can be increased even further if the way services are organized and administered makes it convenient and easy to use the clinic. There are five programmatic features that seem to contribute to increased access and utilization: pregnancy testing services; responsive scheduling of clinic appointments; convenient hours; a convenient location; and simplified admissions procedures.

Pregnancy Testing Services

A "pregnancy scare" is often the motivating factor behind a teenager's initial contact with an organized family planning program. Interviews with a number of providers revealed that an estimated one-third to one-half of their teenage patients come to the clinic as a result of a "pregnancy scare." Patients who do not prove to be pregnant tend--like postpartum patients--to be highly motivated to accept birth control services. The inclusion of such services can, therefore, significantly encourage program access by teenagers.

Responsive Appointment Scheduling

Because a teenager's decision to seek contraception is often difficult, and one that is often put off for a long time after the initiation of sexual intercourse, it appears to be important to respond to the request for service quickly. The length of time teenage patients had to wait for an appointment at the clinics involved in the study ranged from one day to four weeks. The high correlation between long waits for appointments and large "no-show" rates among teenage patients strongly suggests that an extended wait for an appointment decreases utilization by teenagers. Eighty percent of the teenagers indicated that a wait of one week was all right, while 60% felt that a wait of over two weeks was "much too long."

Convenient Hours

It seems important for services to be available for teenagers at a time that does not conflict with school hours or parental demands. Teenagers' preferences in this case seem to relate to the maintenance of confidentiality as much as to convenience. Responses on the questionnaire to the question, "what made it hard for you to come to the clinic" indicated that for some teenagers, the hours that the clinic is open is an important determinant of ease of access. Thirteen percent of the teenage patients said that the clinic was "not open at the right time," 15% indicated that it was hard for them "to get out of school" to attend the clinic, and 13% said that it was "hard to get away from home for so many hours." According to questionnaire responses and patient interviews, the best times for teenagers to attend clinics seem to be during the after-school hours and early evening hours.

Convenient Location

The location of a clinic was another factor that teenage patients cited as influential in their decision-making. For one thing, clinic location was related to the maintenance of confidentiality. That is, teens who did not want their parents, other adults, or their non-sexually active peers to know that they were attending a birth control clinic wanted the clinic located in a place that would not be highly visible. On the other hand, 14% of the teenage patients who completed questionnaires indicated that transportation was a problem for them and 7% said that the clinic was too far away. Thus, to the extent possible, clinics should be located in a place that is not highly visible, but that still offers easy access to transportation.

Deferred Payment

Because teens have limited access to money, it seems important that teenage patients have the opportunity to pay clinic fees in small amounts over a period of time. In those cases where teens truly had this option, they responded favorably and paid their full fee as arranged.

Simplified Admission Procedures

The field research team observed several instances in which clinics had complicated admissions procedures that acted to deter patients from receiving initial services. Procedures that were time-consuming or that required patients to come for admissions processing first and then to return for clinic services on another day were not highly utilized by teenagers.

2.2 Continuing Access

A teenager's first visit to a family planning clinic represents the first step in what is supposed to be a continuing process of contraceptive care. Patients are usually required to return for a "method check" several weeks or months after the first visit (the length of time generally depending on the method that has been prescribed) or for insertion of an IUD if that is the prescribed method. In addition, patients are often required to return for check-ups or contraceptive supplies one or more additional times during the first year of services as well as for an annual check-up between 12 and 15 months following the first visit. However, many patients fail to return to the clinic after the first or second visit.

There are a number of common reasons that keep patients from returning to the clinic. Some move away from the area served by the clinic. Other patients become pregnant--intentionally or unintentionally. Some patients decide to stop using contraception or they opt to use "drug store methods" such as condoms or spermicidal foams. However, according to teenage patients who were interviewed about their experiences with other providers and other clinics, many of them switched clinics because they felt that the clinics they had attended before were too crowded, or dirty, or disorganized, or unresponsive to patients' feelings and needs. This was further confirmed by some of the teenagers in the group of "non-users" who indicated that they had stopped going to the clinic because they were not treated well by the staff or clinicians or because the procedures used by the clinic were too complicated, time-consuming or frustrating.

On the basis of this experience, the URSA field research team hypothesized that satisfaction with the clinic is a major determinant of a teenager's willingness to return to the clinic. The study findings indicated that there are three factors that teenagers attach great importance to when they evaluate a clinic: the way they are treated by the clinic's staff; the way they are treated by the attending clinician (physician or nurse practitioner); and the clinic's efficiency in processing clients.

Staff Attitudes and Treatment of Patients

The character of the interaction that they had with the staff was the single most important aspect of their experience with the clinic for most of the teenagers who completed questionnaires. Seventy-five percent of the teenage patients and 60% of the teenage non-user group said that it was "very important" for the clinic

staff to be "warm and accepting" of teenagers. Teenage patients also ranked this feature first in importance among twelve other program elements. In addition, when asked what they liked best about the clinic, adolescent consumers mentioned "the staff" more often than anything else and described them in terms like "helpful," "respectful," "understanding," "concerned," "warm," or "interested"--or as one teenager said, "they treat you like people, not patients."

In contrast, teenagers describing unpleasant experiences with clinics in the past also frequently mentioned having had problems with the staff of the clinics.

Clinician Attitudes and Treatment of Patients

To teenage consumers, the "main event" of the clinic visit was the physical examination--and most particularly the pelvic portion of the exam. "Fear of the pelvic exam" was the second most critical obstacle to clinic use for teenagers (only "fear of parents finding out"--the need for confidentiality and service without parental consent--exceeded it in importance as an access barrier). Furthermore, 80% of the teenage patients and 74% of the "non-users" indicated that a "gentle and understanding" doctor was a "very important" feature of their experience with the clinic. Seventy-five percent of both the consumers and the non-users also indicated a strong preference for the clinician to explain what (s)he is doing during the physical examination.

Clinic Efficiency

The amount of time that it took for clinics to process patients during a clinic visit ranged from 25 minutes to 4 hours and 20 minutes, with a median time of 129 minutes spent in the clinic.

A substantial number of the teenagers felt that the amount of time that they had to spend to receive services was excessive. Fifty percent of the teenagers who responded to the questionnaire said that they felt the time spent at the clinic was either "somewhat too long" or "much too long"--and "old" patients who were at the clinic for a method check, supplies, or an annual check-up were twice as likely to find the length of time they had to wait excessive. And, when asked what they liked least about the clinic, half of the teenage patients indicated that "the wait" was particularly aggravating.

There were also other factors that affected teen satisfaction with a clinic; albeit to a lesser extent. They included:

Confidence in the Clinic's Competence

There were two things that patients mentioned that pointed to the importance that they attached to the competence of the clinic's staff and the way in which the clinic's services are organized. Eighty-nine percent of the teenage patients and 81% of the "non-users" who completed the questionnaire said that it was "very important" to them for the clinic to be "well organized." In addition, while teenage patients did not seem to have a strong preference for either doctors or nurse practitioners, they were concerned with the "competence" of the clinician. As one patient put it, "I don't care what they are, as long as they know what they're doing."

Since teenagers usually do not have either the experience or the knowledge to make valid technical judgments about either the competence of the clinician or the efficiency of clinic organization, it is likely that they are really talking about the extent to which the clinician's manner and the way the clinic is organized make them feel secure.

Privacy

Interviews with teenagers as well as casual comments that patients made revealed that respect for their privacy is important to them. They did not want their records discussed by staff in the presence of other patients, they disliked having to state their reason for coming to the clinic (e.g., to get birth control service) if they could be overheard by other patients, and they did not feel comfortable having to answer questions about their medical histories without adequate aural privacy.

Furthermore, they were sensitive to any lack of privacy they experienced while dressing or undressing or while being examined by the clinician.

Finally, there were some other aspects of the ways that various clinics organized and delivered their services that were more important to the younger teenagers than to those who were older. The younger teenagers preferred "teen only" services while the older teenagers felt that it didn't matter whether they attended "teen only" or those that served adult women at the same time.

In addition, the younger teenagers expressed more of a preference for young, female clinicians. They also tended to want the clinicians to wear "white coats." While older teenagers, on the other hand, were more inclined to feel that it didn't matter whether clinicians were male or female, young or old, and dressed in street clothes or "white coats," those who did have a preference also preferred female clinicians of any age in "white coats."

2.3 Encouraging Contraceptor Effectiveness

The major purpose of family planning programs for teenagers is to decrease the number of unwanted pregnancies among that age group. The first steps in that process are to assure initial access, to increase their ease and comfort in the clinic setting, and to encourage them to become a "regular" patient of the program. However, the central thrust of the clinic should be directed at increasing the willingness of teenagers to use contraception regularly and to use it properly. Obviously it is difficult to measure the performance of particular programs in developing competent contraceptors without a longitudinal study. Nevertheless, the experience of "non-users" in the study was both indicative and informative in this regard.

Half of the "non-users" had sought birth control services prior to becoming pregnant. Nine percent (9%) of those teenagers who had sought birth control in the past had used private physicians, 19% had used clinics sponsored by hospitals,

and 51% had been to other types of family planning clinics. Thus, 70% of those teenagers who had sought service prior to becoming pregnant had attended organized family planning programs in the past. Many of them reported that they had had positive experiences at the clinics they used, but discontinued using birth control for a variety of reasons. One patient said she kept forgetting to take her pills so stopped taking them altogether. Others had discontinued pills previously, and, not experiencing a period for several months, were convinced they were sterile. Still others discontinued pills due to side effects without seeking advice or alternative contraceptive methods.

There were equally as many, however, who had experienced either what they considered to be poor medical treatment or frustrations in dealing with other aspects of clinic services that led them to cease using a birth control method. To illustrate, one patient who had experienced severe side effects from the pills (extreme weight gain accompanied by loss of hair) and had reported these problems to the clinic was dissatisfied when her concerns went untreated. Another teen ran out of pills and was told to come into the clinic at five to pick up more. When she arrived, they told her to return at six. By that time, she felt so "hassled" that, as she put it, "I went right home and got pregnant." Others found it hard to return for pill refills because of clinic hours conflicting with school. Still others left clinic settings before ever getting a method because they experienced long waits at the clinic service.

The cases cited above suggest that in some instances clinic procedures or poor personal or medical treatment of teenagers by clinic staff led to disenchantment with the clinic. However, in other instances, teenage patients were obviously not helped by the clinic to be effective contraceptors. To be an effective contraceptor, a teenager should have a clear understanding of the possible consequences of sexual activity without contraception; an understanding of the cycle of fertility; sufficient information to choose an appropriate method; a thorough knowledge of how to use her method properly; and information about any potential side effects related to her particular "method of choice." In addition to knowledge, teenagers--and other women as well--also have to be motivated to use their method on a consistent basis. The support of the teenage patient's sexual partner, the extent of his understanding of how and when pregnancy occurs, and his willingness to accept joint responsibility for the use of contraception may be a very important factor in motivating a teenager to use contraception regularly. In the case of some methods such as condoms, foams, or diaphragms, the active involvement and commitment of the teenager's sexual partner may be even more necessary.

Finally, it is also likely that peer support is helpful in encouraging teenage patients--and their sexual partners--to use contraception regularly and properly.

The clinic's task in this regard is threefold:

- to provide teenage patients with information related to contraception and the proper use of various methods of birth control;
- to help teenagers select a method that is appropriate for them in view of their sexual history, their patterns of sexual activity, their medical needs, aesthetic concerns, and social environment; and

- to help teenagers feel as comfortable as possible regarding the use of contraception and to provide--to the extent possible--support for effective utilization of the teenager's "method of choice."

Patient Education

The information-giving task is generally referred to as patient education. The study's findings indicated that clinics vary widely in the way that information is delivered and in the kinds and completeness of the information that is provided. Some clinics used lectures, others "rap" style discussion sessions, and others used only audio-visuals to provide information to the patients on physiology, reproductive anatomy, and birth control methods. Only 20%--one out of five--of the clinics in the study sample gave patients fairly complete information on the various methods, how they worked, and the advantages and disadvantages associated with each, such as convenience, side effects, or effectiveness rates. Moreover, less than one out of every three of the clinics (29%) discussed with patients their sexual history, gave complete information about the various laboratory tests, or gave an explanation of the pelvic exam.

Counseling

The task of helping patients choose a method is usually referred to as contraceptive counseling. Its purpose is to try to make an appropriate match between a patient and a method and to help the patient integrate the use of the method into her life.

The study found that only a few of the clinics in the sample made any attempt to counsel patients with regard to sexual activity and contraceptive use. Only 8 clinics (20%) included a discussion of the patient's sexual activity as part of their services. In five other clinics (12%), sexual histories were routinely obtained, but the information gathered was not then used as the basis for counseling or for any other purpose.

In many cases the providers indicated that they did not offer counseling because they felt that teenagers did not want to discuss their feelings about sex with an adult--particularly a stranger. Their opinion was not, however, borne out by the teenagers' responses to the patient questionnaire. Thirty-six percent (36%) of the respondents said that they would "like a clinic where someone gives me a chance to talk about my relationship with my boyfriend or my personal feelings about having sex." Another 35% of the teenagers indicated that it didn't matter to them, and only 22% indicated that they had a strong negative preference. In addition, 65% of the patients said that being able to get "information about sex" was either "important" or "very important" to them.

The extent to which clinics are able to provide teenagers with support for contraceptive use may be a function of the way method education and related information are delivered, and the way the clinic is structured with regard to the inclusion of the patients' "boyfriends."

When teenagers were asked whether they preferred to learn about various methods and the physiology of sex and reproduction through a lecture or in a "rap" session, they indicated overwhelming support for "rap" style group meetings. Sixty-two percent (62%) of them said that they would rather have "raps" while only 9% indicated a preference for the lecture format.

In general, "rap" sessions covered various aspects of sex and sexuality, including discussions about relationships with boyfriends and parents, and their attitudes toward birth control, as well as providing information about reproductive anatomy, fertility cycles, and the various methods of birth control. Commenting on what they liked about the "rap" session, teenagers said things like, "It dealt with feelings," "I got to ask questions," "The leader shared her own experiences," "Everyone participated," "People opened up with each other," and "It was fun to hear what other people had to say."

There was a strong implication in these comments and others that teenagers liked the fact that the "rap" group offered them a chance to share their feelings and opinions with others and to gain support from their peers for their decision to seek and use a birth control method.

Most of the teenage patients who were interviewed felt that they bore the primary responsibility for contraceptive protection and in most cases they reported that they had been the one who had initiated discussions about birth control with their sexual partner. However, 50% of the teenagers felt that their "boyfriends" were supportive of their decision to use birth control. In fact, in many instances they said that the decision was made jointly with their partner. Thirteen percent (13%) of the teenagers said that they had not discussed birth control with their partners, but felt that their partners would be glad that "they were taking care of it." Only a few teenagers reported that their partners had had any negative reactions--and those were generally related to fears about the potentially negative effects of birth control pills on their "girlfriend's" health.

Given the fact that so many teenage patients derived support from their sexual partners for attending the clinic, it was not surprising to find that 57% of the patients who completed questionnaires felt that it was either "important" or "very important" to be able to bring their partners to the clinic; and 45% of the teenage consumers and "non-users" alike felt that clinics should "encourage guys to come to the clinic with their girlfriends." Only 13% of the respondents wanted clinics for females only--and they were primarily the very young teenage patients--14 years old and under--who still may not be very open about their sexual activity.

Male attendance was observed by the study team in over half (23) of the 40 clinics in the study sample. However, in most instances, there was little for a male to do while attending the clinic. In only a few clinics were males invited to participate in clinic activities such as education or counseling sessions. A few others were given literature to read.

Thus, by their example the clinics tended to support the common notion that birth control is the woman's business, and they failed for the most part to provide male partners with the kinds of information and counseling that might allow them to encourage and support the use of contraception in their sexual relationships.

2.4 Quality of Services

Over 67% of the teenage patients felt that they received "good" or "excellent" medical care at the clinic. However, on the basis of interviews with patients, the study team concluded that most teenagers do not have a well-defined concept of quality care--nor do they have sophisticated knowledge about correct medical procedures. On the basis of their observations of clinical practice, the study team felt that medical care and practices were often inadequate.

In two instances, techniques used to insert IUDs were of questionable medical quality. And the medical screening practices for determining contraindications to particular contraceptives and for determining the existence of side effects were often inadequate. In a number of the clinics the staff, including clinicians, lacked effective interviewing techniques. They were frequently unsuccessful in obtaining all of the information necessary to determine the appropriate birth control method for a patient. Contraindications to particular methods and various medical problems were often neglected due to an inability to conduct effective interviews, or in a few cases, to the fact that the clinician did not review the patient's medical history prior to prescribing a method.

Other procedures related to contraception were often neglected as well. Only 67% of the programs performed all of the lab tests that DHEW has set as minimum requirements for Title X grantees. (Yet 80% of the programs received Title X funds and 90% of the programs received some form of public funding.) And, while observation of clinical procedures indicated that breast examinations were included in the physical exam along with a pelvic examination, only 24% of the clinics performed heart and lung exams, and only 42% performed thyroid examinations.

The present teenage female population also comprises a large part of that group of women who may have been exposed to the drug DES (diethylstilbestrol) in utero. In addition to these women having a higher risk of vaginal cancer, some experts believe patients who were exposed to DES before birth may suffer complications if they use combination oral contraceptives. Yet only one program provided laboratory screening designed to identify "DES daughters," and only two other programs even asked patients about possible exposure to DES. That is, 93% of the clinics in the study sample did not screen for DES exposure in any way.

There were other instances in which the staff responsible for obtaining information about medical history or for conducting "rap" sessions failed to communicate medically relevant information to the clinician. In one example, a patient who was in the clinic for her annual visit mentioned during the "rap" session that she was concerned about a swelling under her armpit. Yet not one staff person during the remainder of this patient's visit elicited this concern from her, nor was there any mechanism for the "rap" group leader to note and communicate this concern to other clinic staff.

Finally, in many of the clinics medical protocols either did not exist, or they were not enforced. Clinicians in those clinics often vary greatly in the procedures they perform and in the approach they take to prescribing contraceptive

methods. For instance, one clinician in a clinic might routinely perform a thyroid exam, while another clinician in the same program might not, or one clinician might not prescribe an IUD for a teenager unless she had been pregnant in the past, while another might prescribe the full range of methods.

CHAPTER 3. CONSTRAINTS

Providers of organized family planning programs are limited in their ability to reach and to provide effective service and care to teenagers by several types of constraints. Some constraints are legislative or relate to public policies at the federal, state, or local level. Other constraints are attitudinal. Still others are related to the extent of the providers' commitment to serve teenage patients and the extent to which they do or do not know how to properly structure family planning services for teenagers.

3.1 Restrictive Legislation

In the last few years, the legal rights of minors to consent for their own contraceptive care have been expanded considerably. However, in 1975, available data indicated that teenagers still needed parental consent in order to obtain contraceptive care in 27 states. In other states, the legislation was ambiguous and neither prohibited nor specifically allowed the provision of contraception without parental consent. Finally, there were some states that had specific legislation enabling the provider to serve teenagers without parental consent.

Particular subgroups of teenagers are often exempted from parental consent requirements, however. For example, teenagers who were married or who have had a previous pregnancy are allowed to consent for their own care in many states that otherwise require parental consent. In other states where the laws are ambiguous and departmental guidelines set forth eligibility guidelines for providers, older teenagers, those who are married, or who have been pregnant previously are often allowed to consent for their own care while never pregnant very young teenagers are required to obtain consent from their parents. Similarly, the laws do not provide uniform coverage for all teenagers even in those states where the legislation clearly is aimed at giving teenagers control over their medical care--in most such states some sexually active youth are excluded from the enabling legislation by age. Thus, the very young adolescent (11-14 years old)--that group which is both most fearful of their parents finding out that they are sexually active and at gravest risk of serious consequences to themselves and their child if they do become pregnant--is also the group that is frequently excluded from service without consent.

Even in those states where the legislative climate was favorable to the provision of services to teenagers, the URSA research team found that providers often made distinctions between serving teenagers and adults or between various subgroups of teenagers. Providers often seemed to perceive themselves on uncertain legal grounds in serving teenagers and they were, therefore, more cautious. For example, providers often have policies restricting the use of IUDs among teenage patients out of fear that if the teenager later suffers serious side effects her parents may have to be involved. In addition, in some states insertion of an IUD is considered to be a "surgical procedure" and is, therefore, more subject to charges of surgical malpractice by parents. In other clinics, legal uncertainty led the provider to require that physicians attend to teenage patients

while nurse practitioners served adult patients. In clinics with a large proportion of teen patients, physician time was thus overburdened, causing long delays with service and in some cases necessitating teenagers returning to the clinic a second time for the examination.

The effect, then, of both specific laws proscribing the delivery of services to teenagers without consent and providers' insecurity in this area is to severely limit the availability of services for teenagers or to require the abrogation of confidentiality in order to obtain services.

3.2 Federal Policies

Since its enactment in 1970, Title X has been the main source of support for organized family planning services. In recent years, however, the philosophy at the federal level has been to de-emphasize the use of public funds for all categories of services, such as family planning, mental health, etc. Emphasis has shifted to new approaches: providing blocks of funds to be used at the discretion of local governmental bodies, such as revenue sharing monies; supporting health service payments through the use of third party mechanisms; and requiring payment for services from those persons who can afford to pay. The rationale behind the move to third party payments and direct fees is the belief that many people are receiving publicly supported services who are eligible for third party payment of the service or who can themselves afford to pay directly for services. The result of these beliefs and philosophies at the federal level is that federal appropriations for Title X have remained at the same level for the past three years. Providers at the clinic level have been encouraged to develop fee schedules and payment systems, and to apply for certification as Medicaid providers.

However, increased provider dependence on patient fees and on third party payments may act as an access barrier for many teenagers--those who can't afford to pay fees; those who are not able to qualify for third party reimbursements; and those who can't use their families' third party reimbursement benefits without revealing to their parents that they are sexually active.

Emphasis on fee-for-service and third party reimbursements will also influence the providers' priorities as well. Providers who are faced with decreased funding from other sources and increasing costs are likely to begin to place more of a priority on reaching and serving those patients who can afford to pay fees and those who are eligible for third party benefits. Second, the Medicaid fee structure may not fully reimburse providers for the cost of the service. Third, providers who have to become more cost conscious may begin to cut back on those things they believe to be non-essential aspects of their services--personalized treatment of patients, specialized teen-oriented staffs, extensive "rap" sessions and counseling, outreach and publicity or community educational efforts. In addition, cost constraints may also be reflected in the type and quality of staff hired. That is, funding limitations may lead providers to cut back on those very features of the clinic's services that are most critical in attracting and effectively serving teenagers.

3.3 Community Attitudes

Community attitudes impacted upon the way family planning services were publicized and delivered by providers in several of the communities visited by the study team. A number of them indicated that they had to maintain a "low profile" because of community disapproval of and opposition to family planning services for teenagers. Thus they either didn't advertise their services at all or they failed to indicate that their services were available to teenagers. In at least one community, a mayor seeking to maintain his popularity with a citizenry noted for conservatism prohibited city agencies from publicizing the fact that they served teenagers.

In other communities the effects of negative community attitudes were more indirect. For example, although the schools in a number of areas were extremely supportive of the efforts of local providers, in other cases school administrators refused to cooperate with providers in any way. In the most extreme instance, the school board in a large metropolitan city explicitly denied providers access to the schools; speakers were not even allowed into the classrooms.

In a few communities, the existence of an organized opposition--usually anti-abortion groups--caused public officials and public agencies to be even more cautious. In some communities, for example, anti-abortion groups demanded "equal time" whenever a staff member of a family planning agency made a presentation in a school--even when the presentation had nothing to do with abortion.

Finally, in some communities, providers reported that they feared that if their programs became the subject of controversy they would also lose contributors.

3.4 Lack of Commitment to Serve Teenagers

Less than half of the providers (45%) identified teenagers as a "high priority" target population when they completed the pre-site questionnaire. The remaining providers (22 of 40,or 55%) considered service to teenagers to be "one among equal priorities."

In general, providers who failed to distinguish between teenagers and adult women in need in terms of their service priorities tended to design and structure their service-delivery systems in ways that were more appropriate to adult women. As a result, programs that assigned teenage patients "equal priority" tended not to be serving large numbers of teenagers in relation to the size of their staffs and budgets and the total number of "patient visits" they had each year. With few exceptions, those providers who stated that they were highly committed to serving teenagers structured their programs to accommodate teenagers and were successful in attracting them to their clinics. Where exceptions existed, further examination revealed that while these providers professed commitment to serving teenagers, they had other priorities that created barriers to clinic utilization by teenagers. For example, some charged high fees, others had clinic hours that were inconvenient for teenagers, and yet others were unwilling to risk the high visibility in the community that would have helped them get across the message that they wanted to serve teenagers.

3.5 Lack of Planning Information

The study's findings strongly imply that just as services designed for adult women unintentionally discriminate against teenagers, services designed to meet the general needs of teenagers unintentionally discriminate against the very young teenager. Clinics delivered services to 12, 13, and 14 year olds in the same way that they delivered services to 18 and 19 year old teenagers and they made no distinctions in the way they tried to reach the various age groups.

There seemed to be several factors that limited the providers' ability to respond differentially to the needs of various subgroups of teenagers. First, providers did not have good data on their patient population in general--whatever their age or demographics. Second, providers were not aware that there were different functional subgroups of teenagers. Third, they didn't know the subgroups had somewhat different needs and preferences.

Few clinics collected the kinds of data on their own that might help them to reshape their programs to meet their teenage patients' needs more effectively--most did not collect useful consumer feedback data on patient preferences and interests at the conclusion of the patient's visit and few, if any, clinics made use of the age-specific data on teenagers provided by the National Center for Health Statistics (NCHS) system.

Most clinic staff find the collection of NCHS data time-consuming and non-utilitarian--they don't feel that they benefit from it. Most of the administrators and program planners feel that the NCHS data is inaccurate and out-of-date by the time that it is returned to them in aggregated form. In addition, few program planners know which pieces of NCHS data are significant for them--they don't know how to use them, and they are often intimidated by the computerized print-outs they receive from NCHS.

NCHS also aggregates data for 15 to 19 year olds and for all those 14 and under. It does not provide breakdowns of the data for adolescents of each age. Thus from the point of view of those responsible for planning services for teenagers, the utility of the NCHS data is even more limited. Even if they know what to look for, and where to find it on the NCHS print-out, they may not be able to get all the data they need or in the form that they need.

3.6 Lack of Program Design Information

Many of the providers in the study sample lacked information about how to best structure their program to attract and serve large numbers of teenagers. Many providers felt isolated and believed that the problems that confronted them were unique. For example, some providers were not aware that other programs had also been confronted with issues like parental consent requirements, organized opposition to family planning, ways of assuring confidentiality or ways of establishing deferred payment systems for teenagers, or techniques for maximizing efficiency in staff utilization.

Those providers that were affiliated with national organizations like Planned Parenthood or with regional consortia were less likely to feel isolated, but almost all of the programs demonstrated the need for additional information about how to plan and operate clinics for teenagers, exemplary projects where they could observe various proven procedures in practice, and technical assistance and training designed to increase the providers' ability to effectively implement such learnings.

CHAPTER 4. RECOMMENDATIONS

4.1 Recommendations for Federal Action

1. *It is recommended that DHEW designate sexually active youth under the age of 18 as a high priority target group for family planning services.*

   Unless DHEW establishes youth under 18 years old as a national priority and acts to support that priority programmatically, it is unlikely that the number of teenagers served by organized family planning programs will be increased substantially.

   In addition, DHEW should consider expanding its concern to include all sexually active youth under age 18. The youngest patient encountered in the course of the study was 12 years old. Some clinics, however, reported that they have served sexually active youth as young as 10 years old. By focusing only on "teenagers," many pre-teenage youth will be neglected or deprived of contraceptive protection.

2. *It is recommended that DHEW provide more financial support to teen services.*

   The study team feels that the changes needed at the clinic level will not come about unless more money is available to support special teenage services. Third party payments and private contributions--in the form of both fees and donations--are inadequate sources of support for organized family planning programs. In fact, putting the burden of support onto these sources effectively discriminates against serving young teenagers.

   In addition, numerous changes will have to be made in the organization of present services. Without additional monies, many providers will not be willing or able to institute these changes and continue to operate.

3. *It is recommended that DHEW actively encourage revisions of state laws, policies, or regulations that limit the ability of teenage patients to consent to their own care.*

   The DHEW Regional Offices should encourage and support efforts by providers and regulatory agencies such as state Departments of Health and Welfare to work to eliminate restrictions wherever they may exist which inhibit teenage patients' ability to consent to their own care. In some states these efforts will require the passage of new legislation. In others, departmental policies at the level of state Departments of Health and Welfare will need to be changed. Most states have legislation permitting the treatment of minors for venereal disease without parental consent. An effort should be made to expand these provisions to include the offering of birth control services. These efforts should be coordinated at the federal level and a rational strategy should be developed to work towards these changes. DHEW's previous experiences in encouraging the development of policies which enabled teenagers to consent to their own VD care may provide a useful precedent. Given the current national attention and concern in the news media about the "epidemic" of pregnancies to teenage women, it seems timely for DHEW to act on this matter.

4. *It is recommended that DHEW sponsor a nationwide public information campaign.*

A nationwide public information campaign designed to acquaint the American people with the personal and social consequences of teenage pregnancy and to develop support for the provision of family planning services to teenagers could do much to create a climate where providers would feel more free--and be more able--to actively recruit teenage patients. In addition, it would encourage teenagers who might otherwise be reticent to seek services.

Past experience with the national VD campaign also should be helpful in designing an effective national effort.

5. *It is recommended that DHEW revise the national patient data reporting system to differentiate among various groups of teenage patients; and encourage regional reporting systems to do the same.*

The NCHS system should revise its reporting system to include several differentiated age groupings for the under 18 year olds. For example, patients might be grouped as follows: 10-12 years, 13-14 years, 15-16 years, and 17-18 years old. DHEW also should encourage regional data systems to revise their age categories and to conform to whatever national age grouping system is adopted.

6. *It is recommended that DHEW develop a three-part training and technical assistance strategy to help providers develop effective programs for teenagers.*

Providers will need considerable assistance in dealing with the legal and medical issues involved in serving teenagers and in learning how to design and operate effective family planning programs for teenagers. DHEW's strategy for providing such assistance should include:

- The development of indirect technical assistance materials on various aspects of program design or clinic operation. Appropriate materials might include filmstrips, slide shows, films, or "how to do it" manuals.

- The identification--or development--of "exemplary" projects that can demonstrate particularly successful approaches to serving teenage patients. This strategy has now been used successfully by several federal agencies. The best of such projects might become regional training and demonstration centers.

- The provision of on-site participatory training and technical assistance for the staff, administrators, and/or clinicians of a particular program or clinic.

7. *It is recommended that DHEW further clarify the Title X medical service guidelines, and act to ensure that providers understand and comply with these guidelines.*

In this study providers in different regions varied in their interpretation of the Title X medical guidelines. One area of confusion concerned laboratory

testing. Specifically, not all providers felt that VDRL screening (for syphilis) was required under the Title X guidelines. Furthermore, many providers were confused about what clinic services they could offer at an initial visit. For example, young women calling for pregnancy testing who were not already clinic patients were turned away. Similarly, potential patients requesting vaginitis treatment were also turned away.

It is strongly suggested that the guidelines be revised to permit and encourage clinics to provide pregnancy testing and vaginitis treatment not only to their present birth control patients but also to potential patients. The offering of these screening techniques is an effective way to recruit new birth control patients among the teenage population.

Programs also should not be discouraged from engaging in abortion counseling and referral if they have other sources of funding to support these activities.

Since past attempts to clarify Title X guidelines by issuing written materials have only had limited success, it might be well to include the subject of Title X guidelines as a formal training topic in Regional training programs.

In addition, DHEW needs to develop procedures for monitoring compliance with the guidelines on a regular basis.

8. *It is recommended that DHEW encourage providers to make better use of their staff and increase their use of volunteers, non-medical personnel and non-M.D. clinicians.*

Many clinics are using more highly specialized and costly staff than is necessary to provide quality care. In a number of programs, volunteers and non-medical personnel are skillfully conducting clinic functions such as individual patient education, group educational sessions, patient counseling, and simple laboratory procedures which traditionally have been performed only by certain types of professionals.

In other cases, clinics are using nurse practitioners, nurse midwives, and family planning specialists to perform the functions traditionally assigned to physicians.

A program that is able to increase its reliance on less specialized staff benefits in several ways. First, the cost of providing the services can be significantly decreased. Second, many teenage patients prefer being examined by a female clinician and women predominate in the allied health professions. Third, the provider can exercise greater control over policies regarding sensitive issues such as the provision of services without consent. If nurse clinicians and family planning specialists could be recruited there would be a larger group from which to hire, enabling providers to choose clinicians who feel comfortable about serving teenagers.

However, nurses and family planning specialists are still not approved for licensing in many states. DHEW can play a significant role in encouraging the development of appropriate licensing procedures in those states.

9. *It is recommended that DHEW continue to encourage and provide support for further research in several areas, including contraceptive technology, DES screening, education and counseling, and breast cancer screening.*

   - Further technical research is needed to evaluate the effects of present birth control methods on young patients and to explore the development of new contraceptive methods appropriate for young women.

   - Further research is needed around the efficacy of present DES screening techniques, in particular those simple techniques which clinics could incorporate into their regular patient screening. This research needs to be conducted immediately, so that potential "DES daughters" can be identified among the population of young women presently attending clinics, if appropriate.

   - Further research is needed around the issues of education and counseling, and their relationship to effective birth control use. Providers currently have no body of research to inform them about the best ways to promote effective contraceptive use.

   - Further research is needed on the appropriateness of breast cancer screening among teenagers. This procedure is presently routinely practiced on all teen patients, but indications exist suggesting that such screening may not be warranted among these very young women. Further study is needed to compile already existing information on the incidence of breast cancer among young women, and to survey researchers and cancer experts in order to develop standard practices concerning such screening for teenagers.

4.2 Recommendations for Action at the Clinic Level

1. *It is recommended that family planning providers establish a separate teen service.*

   The provider's ability to organize an accessible and satisfying service for the teenage client is enhanced if the teen service is separate from regular adult services. The rationale for setting up a separate teen service is not based on teen preferences, for only young teenage clients actually state a strong preference for a separate service. However, a separate teen service increases the provider's efficiency in providing those service features which teenagers do prefer and require. With the establishment of a separate teen service the provider can identify and train staff who would comprise a special teen-oriented team, can implement convenient teen clinic hours, appointment systems, teen-oriented education and counseling activities and fee schedules and can better provide the confidentiality teenagers desire.

2. *It is recommended that family planning providers increase the initial accessibility of their services to teenagers in the following areas:*

- Parental consent and confidentiality: In order to attract and serve teenagers in any substantial number, providers need to offer services that are confidential and do not require parental consent in any manner or form. Providers should establish clinic protocols which spell out the ways in which the confidentiality of the teenager's visit is insured. This includes establishing confidential methods of keeping in touch with the teen patient (communicating the results of laboratory tests or reminders of next patient visit and the billing of the patient fee, if any). Additionally, providers need to allay teenagers' fears by explicitly telling teenage patients those features of clinic operations which guarantee confidentiality.

- Community education and outreach: As with adult patients, teenagers hear about a service primarily through "word of mouth" sources. However, the information received from these sources may be insufficient or inadequate. Thus, many teenagers in this study initially assumed that a family planning service was for adult or married women, i.e., women who were indeed planning families, and not for single teenagers who wished to prevent pregnancy.

  Providers, therefore, need to communicate their existence to the teen population and the fact that their service is available to teenagers. The key elements of outreach communications should explicitly state:

  --that birth control and related services are available (the term "family planning" should not be used in teen outreach);

  --that the service is for teenagers, not only adult women; and

  --that the service is confidential and parental consent is not required.

- Location of clinic facility: A crucial element of teenage utilization of services is the location of the clinic. It must be conveniently located but at the same time provide sufficient anonymity of the patient visit. Providers should re-examine their present location and determine:

  --if teenagers can be seen entering the clinic facility by other teenagers who may be in the vicinity; and

  --if so, is it obvious to any onlookers that the teen is entering a birth control or other sex-related service (such as VD treatment or maternal and child health care).

  Although the size of the community will affect the strength of this factor in inhibiting teen utilization of services, the lack of anonymity of the teenager's visit may severely jeopardize the clinic's ability to attract and serve large numbers of teens, particularly teenagers under 15 years of age and Latina, Chicana or Asian teens.

Clinics that cannot offer the anonymity that teenagers value so highly should consider moving or establishing an appropriately situated satellite clinic.

- Fees and payment plans: Providers should offer free services to teenage clients, since the average teenager has little access to money for family planning, either money of her own or her parents' (especially if she wants to keep her sexual activity from her parents). If providers must charge patient fees, teenage clients should not be expected to pay more than $5.00 at one time. Providers must institute a deferred payment system that provides a real option to the teen client to pay fees in small amounts over a period of time. Many clinics have established a so-called deferred payment system, but the URSA research team observed that discussions about fees were in most cases biased in such a way that a real option to pay later or over time did not exist. In situations where teens were truly allowed the option to pay later, many providers were surprised and gratified to see that teen patients usually paid their fees when they were able.

- Appointment system: Teenagers should not have to wait more than one week and preferably less for a clinic appointment. Long appointment waits contribute to a high patient "no show" rate and severely limit the teen's access to the service. Additionally, providers should experiment more with a staggered appointment system rather than the usual system of requiring numerous patients to attend the clinic at the same time. Staggering patient visits increases efficiency in handling large groups of patients, with the result that the individual patient will spend less time in the clinic. Providers that have instituted staggered appointment systems with teenage clients reported that by and large teens kept their appointments and were highly appreciative of fast clinic processing.

- Hours of the clinic session: Weekday after-school hours, 3-5 p.m., are the most convenient time of day for the average teenager to attend a clinic. In the morning and early afternoon, most teens are in school, and do not wish to inform teachers or school nurses of necessary clinic visits. The teenager's evening hours are usually accountable to parents. Thus, clinics should hold their teen service clinic session between the after-school and dinner hours. Weekend clinic sessions also do not seem to be convenient for teens.

- Pregnancy screening: Providers wishing to attract large numbers of teenagers should provide highly accessible pregnancy testing services to this age group. A pregnancy scare is in many cases a prime motivation for a teenager to attend a clinic facility. Providers should not turn away or make a referral if the teenager only requests a pregnancy test and does not initially want birth control assistance. The results of many teens' tests are negative, providing an excellent opportunity for a discussion of pregnancy prevention. Of course, providers must be trained to handle positive pregnancy test results and be prepared to assist patients in reviewing their options if they are pregnant.

- Signs and directions to clinics: Many clinics situated in a larger facility, such as a hospital or a health department, were frequently extremely difficult to find for a newcomer. Providers need to look at

the directions to their clinic location from the point of view of a newcomer. Easily read signs need to be posted, preferably using the words "birth control" rather than "family planning," and with clear directions on how to find the clinic.

- Admission to the clinic: Providers should allow exceptions for teenage family planning patients so that teenagers are not required to go through lengthy admissions procedures which the larger sponsoring agency (such as a hospital) may require. Additionally, teenagers should not be required to make two visits to receive services. Some clinics require teenage patients to go through an extensive education or counseling session on a first visit and return a second time for the medical exam. From observing the care provided by many clinics which do not have this policy, the URSA team feels that this procedure is not a necessary prerequisite for quality care, and that it creates an unnecessary hardship and barrier for the teen patient.

3. *It is recommended that family planning providers encourage continuing access of the service to teenagers and provide for high teen patient satisfaction of service by instituting the following measures:*

   a. Providers must employ special staff (and special clinicians--discussed in 3b) to serve the teenage client.

      - The teen service staff--whether recruited from within the agency or from without (if necessary)--must be selected according to the following criteria:

        --a voluntary willingness and desire to serve teenagers;

        --some level of acceptance of teenage sexuality, a willingness to become more accepting of teenage sexual behavior and an ability to be comfortable in discussing sexuality;

        --sensitivity to and awareness of the special life conditions of teenagers and a tolerance for normal adolescent behavior; and

        --a willingness to establish personal rapport with teen clients and an ability to feel comfortable with the personal demands some teens will communicate.

      - Criteria for selection of the teen service staff which are not important are the following:

        --age, dress, or "hipness." The quality of the staff interaction is more important to teenage clients than the age or dress of the staff.

        --professional degress. Again, the degree to which the staff establishes rapport and an accepting environment for teenagers is more important than sophisticated professional training. Non-professional staff and volunteers in the study were observed to operate effectively with teenagers.

- The family planning provider must allow for continuing in-service training of the teen service staff. This in-service training should provide for on-going discussion of the numerous problems and issues encountered in serving the teen patient. In addition, since the staff's feelings and opinions tend to be highly "activated" by teenage patients, emphasis should be placed on helping staff to become aware of and to deal with such feelings during the training.

  Particularly pertinent training topics include:

  --How to deal with teenagers in an age-appropriate manner; how to handle dependency or the very personal demands teens will put on staff; how to eliminate patronizing and over-protective staff behaviors;

  --How to provide effective birth control counseling; how to use the decision-making model and how staff prejudices around particular methods affect the counseling they provide;

  --How to provide effective counseling for pregnant teenagers; how to divert staff frustration at seemingly irresponsible teen behavior in this area; and how to offer nonjudgmental assistance to patients in their decision-making;

  --How to deal with teenage sexuality and with the questions and concerns teenagers communicate to staff in the area of sexual activity; and

  --Innovations in the technology of birth control, and its use by and effects on young adolescents.

b. Providers should assign special clinicians to practice in the teen service session.

It is strongly recommended that the clinician participate as a full member of the teen service team, and participate in on-going in-service training. Providers should not utilize hourly clinicians or clinicians who rotate through the teen service as one of their many duties unless they are provided the extensive orientation and on-going training necessary for the clinician to be effective in serving teenagers. From the URSA team's observations, rotating or hourly clinicians employed in clinics in the study lacked the time and interest required for such preparation. Except for special circumstances, URSA feels that the teen clinician must participate as a full member of the teen service team.

- Criteria for selecting the teen clinician are the following:

  --a voluntary willingness and desire to serve teenagers;

  --some level of acceptance of teenage sexuality, a willingness to become more accepting and an ability to be comfortable discussing sexuality;

  --a specific sensitivity to the fears and anxieties of young women concerning the pelvic exam;

  --a familiarity with early adolescent physical and emotional development; and

  --a willingness to establish personal rapport with teen clients.

- Other characteristics of the clinician which are important if the clinic is attempting to serve teenagers under the age of 15 are that the clinician is young, female, and wears a white examining coat.

- The professional status of the clinician, i.e., whether or not the clinician is a physician, midwife, nurse practitioner, or family planning specialist, is unimportant to the majority of teenagers. Additionally, the simultaneous use of two physicians, an OBGYN and a pediatrician, was not seen to substantially improve the quality of care.

c. Providers must rearrange the present organization of their clinical services to increase the efficiency and speed of their teen client processing.

Clinics should:

- Make further use of staggered patient appointments. Education sessions or "raps," if planned, should be held periodically during the session to allow for a more staggered patient flow.

- Increase the number of clinicians practicing in the clinic session. Increased use of nurse practitioners or other paraprofessional clinicians can help to allay the costs.

- Expand the role of other members of the teen service team, such as receptionist, clinic aid or physician assistant, and laboratory assistant to include patient information-giving and orientation activities.

- Increase the use of non-professional volunteers to assist in patient-flow and patient education duties.

d. Providers should incorporate into their present services additional service features which are required to effectively serve the teenager.

Specifically, providers should:

- Increase efforts at orienting teen patients to the various stages in patient processing, what happens at each stage, the purpose of each step, and how to find each service station. This orientation should be communicated in written form, or on posters, and reinforced in the group discussion or "rap," if there is one.

- Return visit schedules for teen patients should not be more frequent than is medically appropriate. For example, some clinics' policies of requiring teenage patients using contraceptives to return to the clinic every three months for re-supply is medically unwarranted in the majority of cases, and poses a hardship for the average teenager.

- If group educational activities are planned, clinic staff should not lecture to teenage clients. Factual information on the various methods of birth control should be communicated by films or other audio-visuals. Any group meeting should allow for informal discussion and a question-and-answer period rather than a lecture.

- Providers should focus on the physical clinic environment to insure that the waiting room and exam rooms are clean, neat, and orderly.

- Clinic staff should be knowledgeable in clinic processing so that patient flow is orderly and efficient.

4. *It is recommended that providers increase their ability to promote effective contraceptive use by their teenage patients in the following ways:*

   - For those teens who wish to include their boyfriends or sexual partners in the clinic experience (primarily the over 15 year olds), providers should encourage their boyfriends' participation. Providers should inform teen patients that boyfriends are welcome; they should provide male-oriented reading material in the waiting room, and integrate the partner into any clinic activity (the "rap," interview, or pelvic exam) in which the teen patient wishes him to be present.

   - Clinic staff should provide factual information about birth control methods using a "decision-making" model; i.e., the advantages and disadvantages of each method should be stressed and information presented in a manner which allows the patients to make an unbiased choice of the appropriate method for her particular situation.

     --Clinic staff should include in any discussion of birth control those methods most commonly used by teens: rhythm, withdrawal, and the condom. These methods should not be depreciated by the clinic staff; their advantages and disadvantages should be presented in an unbiased manner.

     --Providers should increase the amount of birth control counseling provided to the teenager. The counseling session should be an individual one, focusing on the teen's decision to use a particular method, her considerations about the use of her chosen method and alternative methods, the appropriateness of her chosen method to her sexual activity, and her relationship to her sex partner and parents. Clinic staff (including clinician) should not attempt to talk patients out of their chosen method, nor depreciate it unless unless clear medical contraindictions exist which preclude usage.

     --Follow-up of high-risk contraceptors: Providers should identify high-risk contraceptors among their teen clients and focus more staff effort at following these patients' progress over time. If agreeable to the teen patient, staff could periodically telephone or have an outreach worker contact the teen in school to monitor her situation. Additionally, counseling in the clinic during the patient's visit should focus on those factors in her life situation which make it hard for her to continually use contraception.

5. *It is recommended that providers improve the general quality of care provided to their teenage clients by:*

   - Incorporating screening for potential "DES daughters" in their medical screening. Educational materials should be provided to all teenage clients

- about DES. Clinic staff should inquire of all teenage clients if they know of their mothers' use of DES; teenagers should be encouraged to ask their mothers about DES usage if they don't know already. Staff could advise the teenager how to ask her mother without mentioning her visit to the clinic if the teenager desires her visit to be kept confidential.

- Improving the interviewing skills of all clinic staff (including the clinician). The majority of clinic personnel need to increase their skill in obtaining appropriate and sometimes crucial information from patients. Staff should be knowledgeable in open-ended questioning techniques. Additionally, clinic staff need to allow themselves the time to actually listen to what patients are telling them and to be skillful in picking up crucial data and probing for further information.

- Insuring that standard medical protocols are practiced by all participating clinicians. An important feature of a standard protocol is that a reliable means exists which insures that relevant patient background and history information is communicated among the different clinic staff, particularly between the clinician and medical history taker or counselor.

- Including as part of clinic services the diagnosis and treatment of vaginitis symptoms of their birth control patients and potential birth control patients.

SUMMARY

Teenagers are more in need of family planning services than ever before, and at increasingly younger ages. Yet many teens do not know of the existence of contraceptive services available to them, or find out only after their first pregnancy. Family planning services generally are not designed to serve the special needs of teenagers--needs for preservation of anonymity and confidentiality, low cost, sensitive treatment, and flexible scheduling--and will need to make substantial changes in their operations if they are to do so. Changes are also needed at the federal and state levels to increase available funding, to change state and local legal restrictions in serving teenagers without parental consent, to alter state regulations concerning the functioning of nurses and family planning specialists, and to provide more technical assistance to local clinics. However, many of the changes at the local clinic level could be initiated without federal support, given an interest and motivation to serve teenagers.

IMPROVING FAMILY PLANNING SERVICES FOR TEENAGERS

Final Report Submitted To:

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The views articulated in this report are those of URSA, and do not necessarily reflect those of the Department of Health, Education, and Welfare.

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CHAPTER 1. INTRODUCTION

I. SUMMARY OF CONCLUSIONS

Although family planning clinics receiving some form of federal support constitute the major source of birth control for teenagers, they are not reaching large numbers of sexually active teens nor are they reaching them soon enough--especially those who are 14 and younger. In many cases they also fail to promote effective contraceptive use among those teens they do reach.

Three "threshold" conditions exist which a clinic must meet in order to attract teens in the first place: (1) it must make sure teens know it is available to them; (2) it must guarantee confidentiality and anonymity; and (3) it must be affordable. Once these three conditions are met, other secondary factors influence teens to make an initial visit: location, ease of transportation, convenience of clinic hours, length of appointment wait, and ease of admission. Until a clinic meets the three threshold conditions, however, it will not attract large numbers of teenagers--unless it is in fact (or is perceived by teens to be) the only clinic available to them.

Once a teen has made a first visit to a clinic, other aspects of clinic operations strongly influence the degree to which the teenage client is satisfied with the service and will continue to attend the clinic. Of primary importance to teen satisfaction with services are: the interaction with clinic staff and clinician, confidentiality of the visit, length of processing time, and method of fee payment. Less important to most teenagers are the sex, age and dress of the clinician or staff member, staff professional qualifications, teen-oriented decor, and teen-only clinic sessions--sessions which service teenagers only and don't include adult women. Teenagers 14 and younger differed significantly from older teens in the type and manner of services they preferred.

Other aspects of clinic operations potentially influence how effective a contraceptor the teenager will become. These include the nature and extent of patient education efforts and family planning counseling, the quality of medical services offered, and possibly the degree to which sexual partners are included. These service features, in most of the study clinics, need to be greatly improved.

In many instances programs are deficient in scope and quality--lacking needed services such as pregnancy testing and medical treatment for various disorders that might bring teenagers into a family planning clinic, and inconsistent or inadequate in some of their clinical information-gathering procedures.

In addition, numerous external factors contribute to clinics' lack of success in reaching teenagers, including restrictive state legislation (or interpretations of legislation) which limit younger teens' access to birth control without parental consent; federal trends toward cutting back funds and a consequent increased reliance by clinics on patient fees and third-party payments; and federal funding policies which impose limits on providing service. Finally, in order not to arouse ambivalent community attitudes towards teenage sexuality in general and birth control for teens in particular, many providers hesitate to engage in the kinds of activities (advertising, sponsoring speakers in high schools) that would make their existence known to potential teen patients.

II. RATIONALE

There is a broad unanimity of opinion among experts in the field that teenagers in the U.S. population are becoming sexually active at younger ages; for example, J.G. Dryfoos has estimated that the proportion of sexually active unmarried girls aged 15 to 19 has increased from 28% in 1971 to 36% in 1973, or from 2.35 million to 3.34 million. At the same time, birth rates among the very young teenagers are increasing during a period when birth rates for all other age groups in the population are declining. Thus births to teenage mothers are becoming an ever-larger proportion of all births. Between 1963 and 1973, the number of births per 1,000 women increased from four to six at age 14, from 12 to 16 at age 15, and from 32 to 37 at age 16.

Moreover, abortion statistics indicate that many of the births to teenage mothers are unplanned and unwanted. Teenagers comprise only one-fifth of the population of females of reproductive age, yet in 1974, they accounted for one-third of the reported number of legal abortions. Women in the 15 to 19 year old group have a high ratio of abortions to live births, but young women under age 15 have the highest ratio of abortions to live births of any age group in the population.

Pregnancy, particularly an out-of-wedlock pregnancy, often means the end of formal education for the school age girl. Even in those instances where teenage couples attempt to legitimate an out-of-wedlock conception by marriage, the research indicates that there is a higher than average chance that they will remain economically disadvantaged throughout their lives. That this practice is widespread is indicated by the findings of the National Natality Study, 1964-1966, which disclosed that 42% of the first births to married females occurred less than eight months after marriage.

The social and economic consequences of unwanted pregnancies and out-of-wedlock births are not the only problems associated with uninformed and unprotected sexual activities among teenagers, however. There are serious psychological and

physical consequences as well--and, these consequences are suffered by both mother and child in many instances--or even by subsequent children.

Dr. Nicholas Wright of the Population Council has identified a variety of risks associated with teenage pregnancies, including:

- Higher maternal mortality rates for white mothers under 20. Mortality rates are about 30% higher than for mothers in the next higher age group (20-24 years). Deaths due to toxemia are 50% higher for both white and non-white teenagers than for women 20-24 years of age.

- Ratios of fetal deaths late in pregnancy are 15% higher among women under 20 than among 20 to 24 year old women, and the risk increases rapidly as parity increases.

- There is a 30% higher risk of infant mortality among children born to teenage mothers than those with mothers in the 20 to 24 year old range. In addition, there is an even greater differential risk to other live-born children subsequently delivered by teenage mothers.

- Children born to mothers aged 15 to 19 are 36% more likely to be premature (as measured by weight) than the offspring of 20 to 24 year old women. The differential risk is even greater for mothers under 15.

- Teenagers who are unintentionally pregnant tend to delay the decision to obtain an abortion for a longer period than older women in comparable circumstances, and thus, suffer a higher risk of complications.

In a related set of findings, Dr. Rosalind Ting, of the Philadelphia Collaborative Perinatal Study, concluded that very young mothers (those who bear their first child at 15 years or younger) are more than three times as likely to have three or more additional children in the next seven years than are ethnically and socio-economically comparable women between the ages of 20 and 24.

Thus, to summarize, women who begin bearing children during their teenage years have more children; are considerably more likely to lose their children through miscarriage, late fetal death or stillbirth; give birth to premature children; lose those live-born children they do have before their first birthday; and run the risk of much higher rates of maternal death due to complications related to pregnancy or birth.

In addition to the serious threats that adolescent pregnancy represent to the health of the teenage mother, her child, and subsequent children, there are other potential social costs as well. Pregnancy is reputedly the number one cause for dropping out of school among females, and a recent study has estimated that teenage mothers have a suicide rate many times higher than the general population. Finally, adolescent mothers contribute to increased welfare dependency, and in many cases carry the poverty of their own childhoods into another generation.

Thus, the failure or the inability of teenagers to obtain effective family planning services is not only a problem for sexually active teenagers and their families--it is a public problem as well, and it requires decisive public action.

Yet teenagers are receiving a disproportionately small share of publicly funded family planning services. Although there were almost 5,000 publicly funded family planning clinic service sites in 1974 that reported serving 3,281,517 women, only 959,118 were teenagers age 15 to 19. That is, while teenagers (15 to 19) made up 42% of the total women in need of publicly supported services, they accounted for only 29% of the women who actually received services. In addition, while 40% of the adult "women in need" received services, only 23% of the teenage "women in need" were served.

In June 1974, official concern about the extent of unmet need for family planning services among teenagers led the U.S. Department of Health, Education and Welfare (DHEW)to contract with Urban and Rural Systems Associates (URSA) of San Francisco, California, to conduct an evaluation of family planning services for persons under age 18. The objectives of the study were:

1. To obtain data on the accessibility and provision of family planning services to persons under age 18 in a variety of delivery settings (other than offices of private physicians), but with particular emphasis on programs funded directly by DHEW.

2. To analyze the information obtained for elements of good and poor service accessibility and delivery.

3. To make recommendations for improved accessibility and quality of services to the young patient in DHEW-funded programs.

4. To prepare information for dissemination to both DHEW-funded and other programs about successful services for the young patient.

III. METHODOLOGY AND STUDY SAMPLE

To find out why federal support for family planning has not had a greater impact on teenagers--and to make recommendations to increase this impact--URSA assembled a study team of five family planning professionals experienced in the organization and administration of family planning services to teenagers. In consultation with skilled professional researchers, the team designed a study to elicit answers to the following three questions:

1. What encourages teenagers to come to family planning clinics? What discourages them?
2. After their initial visit, what encourages teenagers' continuing attendance at clinics? What discourages them?
3. What clinic activities seem to be most effective in making teenagers effective "contraceptors?"

In addition, as the study proceeded, the URSA team also became aware of the need to include some assessment of the quality of services teenagers receive at family planning clinics.

Information came from three sources: teenagers (both "users" and "non-users" of family planning clinics); the clinics; and the community. Teens were queried as to their background, their use of services, and their satisfaction with the services they received. Clinics were questioned about the nature of their services, their experience in dealing with teens, and the special problems they perceive in serving this group; the study team also observed the clinics in operation and assessed the quality of the service they provide. Finally, the team examined the extent to which the national, state, and local laws and attitudes under which the clinics operate either enhance or detract from their effectiveness in reaching and serving teens.

In order to find answers to the study questions identified, the URSA team carried out the following activities:

1. The URSA team, in consultation with the DHEW Project Officer and the DHEW Regional Family Planning Staffs, designated eight major metropolitan centers as "study areas:" New York City, Baltimore, Atlanta, Houston, Chicago, Denver, San Francisco/Oakland, and Seattle.

It was decided to focus primarily on large cities, since they contain the majority of publicly supported services as well as the women who need them. The criteria for selecting specific cities were:

- that a variety of agencies sponsoring family planning clinics operate within the city;
- that these clinics serve teenage clients;
- that the various regions of the country be represented;
- that cities whose clinics had been the object of previous intensive study be avoided.

2. The study team selected 40 clinics within the eight study areas for intensive study.

The clinics were selected to include all the different types of agencies which sponsor publicly-supported family planning services.*

Type 1. County hospitals. Five clinics (12.5% of the study sample) were sponsored by four county hospitals.

Type 2. Private hospitals. Four clinics (ten percent of the study sample) were sponsored by four non-proprietary private hospitals--facilities not administered by a city or county public entity.

Type 3. Health departments. Eleven clinics (27.5% of the study sample) were sponsored by 12 health departments, which included both county and city entities.

Type 4. Other multi-service agencies. This category includes various multi-purpose programs that provide a variety of services in addition to family planning --neighborhood health centers, "free" clinics, YWCA's and teenage centers, and women's health clinics. Four clinics (ten percent of the study sample) were sponsored by six agencies of this type.

Type 5. Planned Parenthood. Planned Parenthood is a national organization whose only purpose is to provide family planning services. Ten clinics (25% of the study sample) were sponsored by eight Planned Parenthood affiliates.

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*"Clinic" refers to the clinic service site; "sponsoring agency" refers to the organization that administers the clinic. The team studied 40 agencies and 40 clinics, although for a variety of reasons--three agencies ran more than one clinic , and seven agencies did not permit the team to visit their clinics while in operation--there is not a one-to-one correlation between agency and clinic.

Type 6. Other family planning agencies. These are community agencies which, like Planned Parenthood, are single-purpose family planning organizations, although they have no national affiliation. Six clinics (15% of the study sample) were sponsored by six such agencies; half of them began as OEO-sponsored programs.

Graph 1 (below) shows that single-purpose family planning agencies (Types 5 and 6) make up 40% of the study sample; multi-purpose organizations (those that provide services in addition to family planning) make up the remaining 60%.

The predominance of hospitals, health departments, and Planned Parenthoods in the study sample reflects roughly their importance in providing family planning services nationally. "Other family planning agencies" and "other multi-purpose agencies" (Types 6 and 4) are purposefully over-represented in the study sample, so that the study team could assess the impact on teen utilization of all existing types of agencies and their clinics.

GRAPH 1

PROPORTION OF STUDY CLINICS BY SPONSORING AGENCY

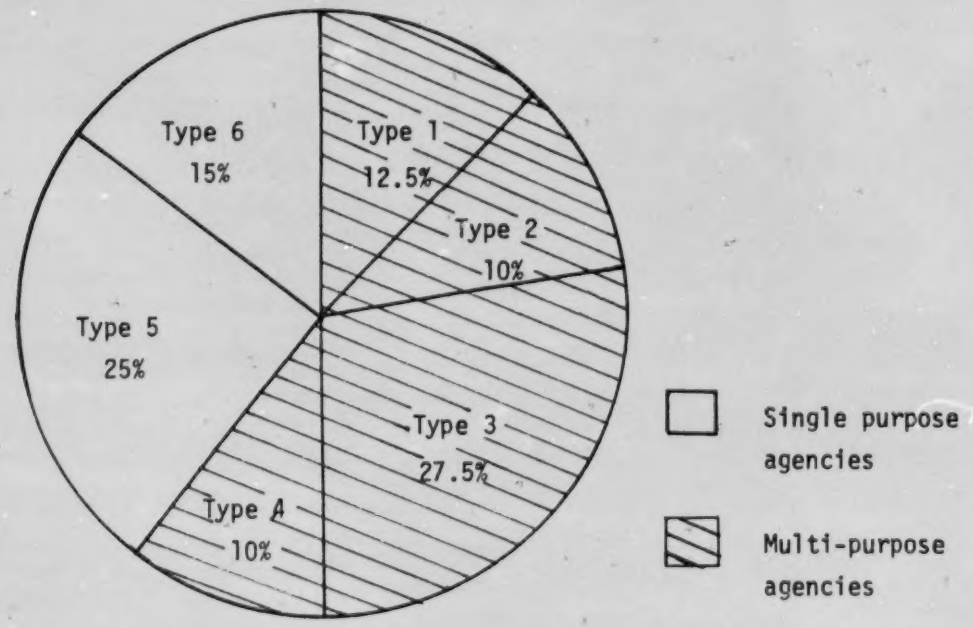

Table 1 reflects the geographic distribution among the eight study areas of study clinics by type of sponsoring agency.

TABLE 1
NUMBER OF STUDY CLINICS IN EACH STUDY AREA BY TYPE OF SPONSOR

Study Area	TYPE OF SPONSORING AGENCY*						
	Type 1	Type 2	Type 3	Type 4	Type 5	Type 6	TOTAL
Seattle			2	1	1	1	5
SF/Oakland Bay Area		1	1	1	2	1	6
Denver	1		1		2		4
Baltimore		1	2		1	2	6
Houston			2		1		3
Chicago	1	1	1		1	2	6
Atlanta	3		2	1	1		7
New York		1		1	1		3

* Type 1. County hospitals
Type 2. Private hospitals
Type 3. Health departments
Type 4. Other multi-service agencies
Type 5. Planned Parenthoods
Type 6. Other family planning agencies

The study team also made sure to include a representation of urban, suburban, and rural clinics.

Urban: Thirty-one clinics (77.5% of the study sample) were urban, a proportion that roughly corresponds to the national predominance of urban family planning clinics.

Suburban: Three of the clinics (7.5% of the study sample) were suburban, located outside Chicago and Atlanta. They were either public health departments (Type 3) or other family planning agencies (Type 6).

Rural: Six of the clinics (15% of the study sample) were rural, selected to be far enough from a major city not to be suburban, and close enough to be within driving distance. One rural clinic was selected in each of the following

areas: Seattle, San Francisco/Oakland, Denver, Atlanta, and Baltimore. Like their suburban counterparts, these clinics were either public health departments (Type 3) or other family planning agencies (Type 6).

The study sample further reflects a variety of family planning programs as to size: large (annual budgets over $600,000, 20,000 or more patient visits per year; and a full-time-equivalent staff of at least 20); small (annual budgets under $100,000; 4,000 or fewer patient visits per year; and a full-time-equivalent staff of not more than ten); and medium (all programs in between).* Table 2 shows this distribution by type of sponsoring agency:

TABLE 2

SIZE OF FAMILY PLANNING PROGRAM BY TYPE OF SPONSORING AGENCY

Program Size	TYPE OF SPONSORING AGENCY**						
	Type 1	Type 2	Type 3	Type 4	Type 5	Type 6	TOTAL
Small	2	3	2	4			16
Medium	3	1	7	1	1	1	14
Large			3		7		10

**Type 1. County hospitals
Type 2. Private hospitals
Type 3. Health departments
Type 4. Other multi-service agencies
Type 5. Planned Parenthoods
Type 6. Other family planning agencies

* In the case of multi-purpose agencies, these figures reflect only resources allocated to family planning services.

3. The team collected data (by means of questionnaires and interviews) and conducted on-site visits for each of the 40 clinics in the study.

Prior to the team's visit, questionnaires were sent to most participating clinics, eliciting information on clinic size, sources of support, type of clinic, number of teen and adult patients served, nature of clinic staffing and range of services provided.

During the week that the study team spent in each study area, it conducted loosely structured, open-ended interviews with agency administrators, clinic supervisors, and staff--counselors, medical aides, and clinicians.

The team tried to visit clinics during sessions when teens were expected to be present. In those cases where they were granted permission by patients and staff, members of the study team also followed teen patients through all the various clinic procedures.

4. The study team received 423 completed questionnaires and conducted 105 interviews with teenage women patients at 36 of the 40 clinics in the study.

At the beginning of a team's visit to a clinic session, all patients 18 or under were informed about the study and asked to participate. A study team member explained the questionnaire (see Appendix 1 for a sample copy) to each patient who agreed to fill one out, and assured her of the confidentiality of her responses. Most participants completed the questionnaire while they were waiting. It elicited (a) demographic and background data, (b) reactions to specific aspects of the clinic experience, and (c) preferences concerning the provision and quality of the clinic services.

When the patient had completed her questionnaire, usually by the end of her clinic visit, a team member asked her to participate in a ten- to twenty-minute interview. Although most patients accepted the questionnaire, many declined to be interviewed because of lack of time, embarrassment, or shyness (even though they were assured their responses would be held in strict confidence). The loosely-structured interviews probed for further reactions to clinic service, and also sought new information on how the patient had heard about the clinic, her motivation to use clinic services and her knowledge of other family planning services available to her.

5. <u>The study team analyzed the study sample according to race, age, socioeconomic status, marital status, living arrangements, prior history of pregnancy and age at first sexual intercourse</u>.

The 423 responses to the questionnaires were divided among urban, suburban, and rural clinics in just about the same proportion as the proportion of those clinics in the study sample: 83% from urban clinics, ten percent from suburban clinics, and seven percent from rural clinics. From the information thus gathered, the study team was able to put together a profile of teen patients in the clinics under study.

As to their race, age, socioeconomic status, and living arrangements:

a. As a group, they accurately reflect the local economic situation (as indicated by per capita income and percent below poverty level) in each of the eight study areas.
b. Eighteen percent of the teens in the study sample responded affirmatively when asked if they or their families had been on welfare within the last three years. This percent is roughly equal to the national proportion of teen family planning patients receiving public assistance. Of those teens in the study who indicated they or their families had been on welfare three-fourths were black.
c. Half the teens in the study sample were black, and virtually all of them (95%) were in urban locations (as against only 66% of the white patients). The racial composition of the rest of the teens involved in the study was: 38% white, three percent Latina (Puerto Rican or Spanish-surnamed), one percent Asian, and two percent other. Six percent did not respond. (The number of Latina, Asian, and "other" responses was insufficient to generate further analysis of their data by race.)
d. Fully 75% of the teens in the sample were older--16, 17, and 18 years old. Among the younger teens, however, black patients appeared in far greater proportion: 26% of the black teens were 15 and under, compared with 17% of the white teens.

Table 3 breaks down the study sample by race and age:

TABLE 3
TEEN CLINIC CONSUMERS BY AGE AND RACE

Age	RACE		% of Total Sample
	% of Black Teens	% of White Teens	
Under 14	3%	0%	2%
14	9%	3%	6%
15	14%	14%	14%
16	26%	21%	23%
17	30%	38%	32%
18	18%	24%	20%
No Response	-	-	3%
TOTALS	100%	100%	100%

e. Eighty percent of the study sample lived with either one or both parents. Most of those not living at home were older white teens.

As to their age at first sexual intercourse:

a. Over 90% of all patients in the study sample (including the one-third who were visiting the clinic for the first time) had already begun having sexual intercourse--75% of them for more than a year before visiting the clinic. This substantiates other studies which now show that use of birth control does not precede the onset of sexual activity in most instances.

b. Black teens experienced their first intercourse earlier than white teens: 20% of the black patients had had sexual intercourse before age 14, compared

with only ten percent of the white patients. Conversely, white patients reported first intercourse occurring at ages 16 or 17 twice as often as black patients (see TABLE 4).

TABLE 4
AGE AT FIRST INTERCOURSE BY RACE

Age at First Intercourse	RACE	
	% of Black Teens	% of White Teens
Under 14	20%	10%
14	18%	18%
15	22%	20%
16	17%	32%
17	5%	11%
18	0%	7%
No Response	18%	2%
TOTALS	100%	100%

As to prior pregnancies:

Sixty-nine percent of the study sample had never been pregnant. This group included 85% of the white teens and 62% of the black teens.

6. For purposes of comparison with teen consumers or "users" in the study sample (those teens reached at the family planning clinics) the study team sought information from 118 "non-users"--teenage women not currently enrolled in family planning clinics.

In consultation with the DHEW Project Officer, it was decided these women should be selected from among participants in pre-natal services and/or special school programs for pregnant students--teenage women, in other words, who were either pregnant or who had just had babies. The purpose behind selecting a group of "non-users" was to

establish whether the teens using family planning clinics were a unique sub-group of teenagers in their community, and to determine whether teenagers who are sexually active but not currently using clinic facilities have needs and desires for clinic services that are different from those of teens already being served. (As it turned out, most of the "non-users" had in fact been "users" at one time, a finding which is discussed later in this study.)

The study team solicited information by means of questionnaires given to women at programs in four schools and three hospitals in all the study areas except New York City. Questions pertaining to demographic data and clinic preferences were the same as the questionnaire for "user" teens, although other sections were appropriately modified for the "non-user" pregnant or post-partum women. Also, in individual or group interviews with approximately 60 "non-user" women, they elicited information about their knowledge of available family planning services, and their reactions to any family planning services that they had used before becoming pregnant.

The major demographic difference between the "users" and "non-users" was one of race: over 85% of the "non-users" were black, reflecting the fact that the team collected "non-user" data only from urban locations, all of which had high concentrations of blacks. Given the preponderance of black "non-users," the experience and background information of these black "non-users" will be compared only to that of the black "users."

The age distribution of the black "non-users" and black "users" were similar. In addition, the age at first sexual intercourse of the black "non-users" was similar to that of the black "users" who had had a prior pregnancy. For both of these groups, sexual activity was begun more often at younger ages than for black teen "users" not reporting a previous pregnancy (see TABLE 5).

TABLE 5
AGE AT FIRST INTERCOURSE AMONG BLACK TEENS IN THE STUDY

Age at First Intercourse	BLACK TEENS "Non-Users"	"Users" Previously Pregnant	"Users" Never Pregnant
Under 14	31%	27%	17%
14	20%	20%	18%
15	20%	20%	26%
16 and older	12%	23%	24%
No Response	17%	10%	15%
Total	100%	100%	100%

The socioeconomic situation of the "non-users" was in general lower (with a higher instance of welfare experience) than among black teens in the consumer group.

The living situation of the "non-users" also differed from the black "users" in the following respects:

- Twenty-eight percent of the "non-users" lived out of the home, as against 11% of the black "users;"
- Fourteen percent of the "non-users" stated they were married, as against only two percent of the black "user" group.

7. To survey attitudes of teen consumers' sexual partners, the study team administered a questionnaire to 46 males attending 23 of the 40 family planning clinics in the study.

The purpose of this questionnaire was to find out how much influence boyfriends had on their girlfriends' use of clinics and birth control, to ascertain the extent to which boyfriends were included in clinic activities, and also to obtain males' opinions about clinic operations and their role in the clinic.

The 43 male respondents ranged in age from 13 to 33, although most were between 15 and 21. Of those who responded to questions about race, 20 said they were white, 11 black, and two were Spanish-American.

8. The study team examined the complex of federal, state, and local laws, regulations, and attitudes which affect the provision of family planning services to teenagers.

The team reviewed the pertinent legislation and administrative regulations. In addition it also sought to determine the perceptions of agency administrators and clinic staff as to pertinent legislation and regulations. Included in this examination were:

- Laws and departmental guidelines affecting service to teenagers in the eight study areas, and interviews with agency and clinic personnel concerning the impact of these laws and attitudes.
- Changes in federal funding priorities, and their effect on services to teenagers.
- Those policies and regulations which all family planning agencies accepting public funds must follow, the extent to which they do in fact follow them, and how these policies and regulations encourage or discourage service to teens.
- Community attitudes and values regarding the use of family planning services by teens.

Finally, the team also noted instances in which personal attitudes of staff members influenced the provision of service to teens.

Based on the information thus collected--data from the clinics, "user" and "non-user" teens, a review of the legislation and community attitudes and the team's own on-site observations and judgments--the study team drew up its conclusions and recommendations.

Despite the fact that this study was not based on statistically controlled sampling techniques, the team feels strongly that its conclusions generally reflect the national situation regarding the provision of family planning services to teenagers.

The team further believes that the recommendations following from these conclusions will assist DHEW and the family planning provider agencies interested in serving teenagers to improve and extend these services.

In considering the conclusions and recommendations, however, one should be aware of the following limitations inherent either in the nature of the study as designed in cooperation with DHEW, or with the data-gathering.

- Due to the fact that agency, clinic, and teen participation in the study was completely voluntary, the team was unable to carry out all its activities in every clinic in the study.
- All data-collecting instruments were prepared in consultation with two local groups of advisors: a group of family planning and social research professionals, and a group of teen advisors. They were also extensively pre-tested with a variety of teens at different clinics. There were a number of questions that the study team wanted to include in the questionnaire that had to be deleted because the U.S. Office of Management and Budget deemed them to be too personal or sensitive. These included questions about frequency of sexual intercourse, number of sexual partners, perceived peer group attitudes, knowledge of fertile period, regularity of birth control usage, and other issues of sexual activity and awareness.
- The original intent of DHEW was to look at women under the age of 18. However, in the course of pre-testing the questionnaires and collecting pre-visit data from the clinics, it became apparent that the number of teens under 18 would be too small to be useful. The team therefore decided to administer the questionnaire additionally to 18-year-old clinic patients. (Their responses were not significantly different from the other older teens in the study.)
- There were instances in which the agencies and clinics were unable to provide information requested by the study team on their patient populations and other issues. (In fact, the lack of accurate and complete information is an important issue which the team addresses in the study itself.)

- Finally, there was the constraint imposed by the fact that the study team was able to talk only to those teenagers who (a) were already in the clinics or (b) were participating in pre- or post-natal programs or school programs for pregnant teenagers. The first group, therefore, represents a self-selected group of teenagers who have overcome many of the barriers to service that may affect their peers who are not in the clinics. The "non-user" group was selected on the basis that it was the only group of teens available to the study team that hypothetically had not availed themselves of family planning services. To a certain extent comparisons between these two groups yielded valuable information--although in talking with the "non-users" it quickly became apparent that many of them had, in fact, been "users" at one time. While this finding reduced their usefulness as a comparative population, in one sense, it also highlighted the degree to which family planning services are ineffective in preventing unplanned pregnancies among their teenage patients.

CHAPTER 2. CONCLUSIONS

I. OVERALL EFFECTIVENESS IN REACHING TEENAGERS

1. Overall, family planning clinics are not attracting enough teenagers to their services.

Young women are considerably underserved in the eight study areas surveyed. The number of patients 18 years and under served in the two study areas with available community-wide statistics show that in one area only 18% and in the other 52% of teenagers "in need"* of publicly-supported services were being seen. Though patient statistics, by community, were unavailable in the remaining study areas, the team's analysis of individual study programs indicates that clinics are generally unsuccessful in reaching teenagers proportionate to their need. And in many cases the teenagers clinics are reaching have already been pregnant. For example, in the one study area mentioned above--where only 18% of teens in need are being seen--fully 45% of these teenagers had had at least one pregnancy.

As to individual programs, only six (15%) of the 40 study clinics served large numbers of never pregnant teenagers proportionate to their size. These six programs were sponsored by all types of service providers; no one particular agency type predominated in drawing large numbers of teens. Given that the team excluded from the study those providers in each community who were not serving teenagers, it is surprising so few were seeing large numbers of teens. This lack of success in attracting numerous teens points to the effectiveness of barriers deterring teenagers from using family planning clinics--both motivational barriers and those that clinics themselves create.

2. Clinics are not reaching teenagers soon enough, and black teens, in particular, need to be reached at younger ages.

Virtually all (94%) of the teens attending clinics in the study had had sexual intercourse some time before coming in for birth control service. More importantly,

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*URSA used the Joy Dryfoos formula to estimate teenagers in need of publicly-supported family planning services: of the number of teenagers in the population, 88% are assumed never married, 23% of these are assumed sexually active and 80% of these are assumed not desirous of pregnancy.

fully 75% of the patients visiting the clinic for the first time had had their first intercourse at least one year before. Assuming that in most cases this initial sexual experience represents the onset of more or less regular sexual activity and is not an isolated event, these teenagers are risking pregnancy long before they reach a clinic. In fact, almost 30% of the teen clinic consumers in the study had been pregnant before, pointing to the fact that clinics are not reaching teenagers at young enough ages.

The study findings show that the earlier first sexual intercourse occurs, the greater the likelihood that a girl will become pregnant. Black teens attending clinics in the study were twice as likely to have begun sexual activity before the age of 14 as the white teens. As expected, 40% of the black teens had had a pregnancy by the time of their clinic visit compared to only 15% of the white teens. The correlation between early sexual activity and teen-age pregnancy is supported by the experience of the black "non-user" teens, who were all pregnant and also began their sexual activity at quite young ages (see TABLE 6).

Very few of the study clinics were seeing the young teenager--under 14 or 15 years of age-- and this subgroup is particularly underserved. The study team believes that the primary reason for this is that younger teens in the study, both white and nonwhite, have far greater needs for "special treatment" than older teens, treatment which was frequently not available and which programs have difficulties in providing.

TABLE 6
AGE AT FIRST INTERCOURSE AMONG TEENS IN THE STUDY

Age at first intercourse	BLACK TEENS			WHITE TEENS
	% of "Non-Users"	% of "Users" Previously Pregnant	% of "Users" Never Pregnant	% of "Users"
Under 14	31%	27%	17%	10%
14	20%	20%	18%	18%
15	20%	20%	26%	20%
16 and older	12%	23%	24%	50%
No Response	17%	10%	15%	2%
TOTALS	100%	100%	100%	100%

3. Family planning clinics are failing to promote effective birth control use among the teenage patients they do reach.

The study team found that among the "non-users," half of them had sought birth control prior to their pregnancy. They were not, strictly speaking, "non-users" at all. Of this number, nine percent had gone to private doctors, 19% to hospital clinics, and 51% to other types of family planning clinics. Thus, 70% of those teenagers who sought service prior to becoming pregnant had previously attended organized family planning programs.

What went wrong? Among those who had gone to family planning clinics, the blame seems to rest equally with ineffective education and/or counseling and unresponsive clinic personnel and policies. Some patients, for example, having discontinued their pills and still not experiencing a period for several months, concluded they must be sterile. Others, noticing disturbing side effects, discontinued using their birth control method but did not seek advice or alternative methods. One patient reported that she kept forgetting to take her pills so often that she simply stopped them completely.

There were equally as many instances reported of poor medical treatment or frustrations over clinic procedures: failure of clinic staff to deal with unpleasant side effects of the pill reported by teenagers; conflicts between school hours and the time when refills of pill prescriptions were available; inordinately long

waits for service; and simple red tape. One girl was told on the phone to come in at five o'clock for a pill refill, at which time she was told in person to come back at six. She felt so "hassled" that, as she put it, "I felt like going right home and getting pregnant."

4. There is no single type of provider that attracts more teenagers than any other, relative to the size of its total operation.

For each provider type--county hospitals, private hospitals, health departments, Planned Parenthoods, other family planning agencies, and other multi-service agencies --the proportion of teenage patients to the size of each program was the same: about 20% are seeing large numbers of teens for their size, 40% are seeing medium numbers of teens, and 40% are seeing small numbers of teens. These percentages were arrived at by comparing the size of the sponsoring program (rated small, medium or large by a method described on page eight of this report) with an average caseload of new teenage patients for each program.*

The study team feels there are too many variables affecting teenage utilization of clinics simply to equate large proportions of teenage patients with teen satisfaction with the clinic. For example, two programs in the study that attracted large numbers of teenagers did so mostly because they were the sole providers of public family planning services in their community. In general they did not grant a very high priority to serving teens, nor did they offer some of the features to which teens respond most favorably. Substantial teenage utilization of particular programs is thus more a function of other factors than the type of agency sponsoring the service.

5. Different types of providers, however, attract different types of teenagers, more because of their location and history of services than any specific commitment.

The county hospitals, private hospitals and the two urban health departments in the study all attract basically the same types of teenagers: when compared with the entire study sample of teen users, teens at these clinics were more often poor

*Less than half the agencies in the study were able to provide statistics on the number of new patients under 18. In these cases slightly less comparable data were used--either from regional data collection systems, or provider estimates on the numbers of patient visits.

and black. They constituted almost all of the teens in the clinics who had had a prior pregnancy; three-fourths of them were attending the clinic with their parents' knowledge.

In contrast, teens at Planned Parenthoods, community family planning agencies, and to some extent suburban health departments tended more often to be white and more affluent. Far fewer of them had been pregnant before, and most were attending the clinic without their parents' knowledge. Teens seen at rural health departments and multi-service agencies (Type 4) do not fall so clearly into this pattern.

TABLE 7

TEEN PATIENT CHARACTERISTICS BY TYPE OF PROVIDER

TEEN PATIENT CHARACTERISTICS	Provider Type				
	1 County Hospitals	2 Private Hospitals	3 Health (Urban) Departments	5 Planned Parenthoods	6 Community Family Planning Agencies
Previously pregnant	44%*	52%	41%	16%	21%
Never pregnant	54%	48%	59%	80%	75%
Black	84%	77%	97%	34%	33%
White	8%	8%	0%	55%	56%
Welfare: Yes	35%	42%	30%	13%	14%
No	61%	52%	70%	64%	81%

*Categories do not add up to 100% due to "No Response" rates.

There are several reasons for this polarization. In the first place, the hospitals and urban health departments are all located in inner-city neighborhoods with dense populations of black, poor and near-poor residents. Many of the teens view them as their "family doctors," and tend to go to them for any health problem (including maternity care). These hospitals and urban health departments also have higher visibility than the smaller clinic devoted only to family planning--and have a reputation for free or low-cost service.

For a variety of reasons suburban health departments, along with Planned Parenthoods and community family planning agencies, attracted larger proportions of white, non-poor teens. Most suburban health departments were located in white, non-poor neighborhoods and served predominantly white communities. The Planned Parenthoods and community family planning agencies tended to give the feeling of a private doctor's office which middle-class women have always associated with health care--rather than the seemingly confusing multi-purpose agencies such as county hospitals or city health departments. Finally, and perhaps more importantly, because of their relatively greater affluence, teens in the Planned Parenthood clinics were less discouraged by the prospect of having to pay a fee.

6. Fewer than half the programs in the study rated service to teens a high priority; those that backed up a commitment with action tended to be more successful.

From the results of interviews with providers and responses to the pre-site questionnaire, less than half of the providers (18, or 45%) identified teenagers as a "high priority" target population. The remaining providers (22, or 55%) considered service to teenagers to be "one among equal priorities."

In general, providers who failed to distinguish between teenagers and adult women in terms of their service priorities designed and structured their service delivery systems in ways that were more appropriate to adult women. As a result, programs that assigned teenage patients "equal priority" tended not to meet the special needs of teenagers and were not serving large numbers of teenagers in relation to the size of their staffs, budgets, and the annual number of "patient visits." With few exceptions, those providers who stated that they were highly committed to serving teenagers structured their programs to accomodate teenagers, and were successful in attracting them to their clinics. Where there were exceptions, further examination revealed that while these providers professed commitment to serving teenagers, they had other priorities that created barriers to clinic utilization by teenagers. For example, some charged high fees, others had clinic hours that were inconvenient for teenagers, and yet others were unwilling to risk the high visibility in the community that would have helped them get across the message that they wanted to serve teenagers.

7. Family planning agencies do not have access to the kinds of statistics on present and potential teenage patients they need--either to assess the impact of existing programs or to plan new efforts.

In collecting data on the numbers and characteristics of teenage patients serviced by each program in the study, the team ran up against the following inadequacies:

- Inconsistencies between regional and national NCHS data collection systems. Since most of the study clinics use Title X funds and thus use the National Center for Health Statistics (NCHS) guidelines for reporting patient statistics, the study team used NCHS data categories when requesting data from providers as to numbers and characteristics of teen patients. In five of the study areas, agencies report patient statistics directly to the national system. However, in three study areas, there are regional collection systems interposed between the clinics and the national system--and there are some significant inconsistencies between these sytems in reporting patient age.

- Provider's inability to isolate patient counts by age. In order to learn the number of patients under 18, the study team had to request the number of new patients under the age of 18 that were served in 1974, since the national reporting system identifies patient age only in the "new patient" category. However, for the following reasons this information was unavailable from over half of the study programs: 1) 13 programs were in the three study areas with regional collection systems, all three of which included 19-year-olds in their teenage patient category; so that those patients 18 years of age and under could not be identified; and 2) seven programs (including one that did not receive Title X funds) could not supply any data on the age of patients.

- Insufficient breakdown of teenage patient data. Grouping 18- and 19-year-olds with the increasing numbers of patients from the ages of 12 to 17 does not provide an adequately detailed statistical picture of these younger patients, even though they are the patients most in need of special treatment. Even among those 18 agencies that did provide age-definitive information on teen patients, only 11 of them could provide information on race, pregnancy history, and welfare status.

- Lack of data on target population teenagers in "need" of service. The study team collected what little information it could on the numbers and types of teens in need of clinic services from sources other than the agencies and clinics themselves. Given the difficulty the team experienced

finding this information, it is assumed that many of the agencies and clinics are not aware of it -- or in any case do not use it.

8. The policies and procedures of family planning agencies and clinics do not reflect a knowledge of their teenage patients' lives and feelings.

Certain aspects of the teenager's life situation affect their needs for particular staff attitudes and clinical features, many of which were absent in the clinics studied. The study team believes that what it learned about teenagers in the course of the study will illuminate its conclusions that pertain to clinic policies and procedures.

- Ambivalence towards sexual activity. Teenagers, and especially young teenagers, are not immune to community attitudes against sexual activity before marriage. Most deny the reality of their sex lives. Like many older people, they often think of sex as the result of being carried away by the moment. Many claim they were subtly pressured into sex by peer group pressure. Making an appointment to get contraception represents a degree of advance planning that contradicts this mythic view. It also bespeaks a willingness to take responsibility for their actions that represents a big step towards maturity, one they frequently need a lot of help and understanding to make. They therefore need especially responsive programs with a minimum of logistical obstacles; they also need the assurance of knowing they will find staff members willing to go more than halfway to help them meet their responsibility.

- Dependence on adult authorities. Despite conventional wisdom, sexually active teenagers are by no means totally free spirits. Most of them live at home, and go to school; their time is not always their own. If they choose to keep their visits to family planning clinics private (as the overwhelming majority do), they need services provided in such a way as to guarantee this privacy. Although the parental consent rule which many clinics impose looms as the largest obstacle to confidentiality, there are other contributing features of clinic operations--the time of the clinic session, the length of the wait, the cost and/or the information required to qualify for free or low-cost care. Added to these are the time and money required to get to a clinic. These are perhaps minor inconveniences for older women who are more independent and may feel they have nothing to hide, but they can be major hurdles to teens who want to keep their activities from parents, school authorities and friends.

- Ignorance and fear. Many of the teens in this study were ignorant of the pertinent facts of sexual reproduction and birth control. Even those who were using (or had used) birth control methods frequently did not know how they worked, or how they must be used to guarantee effective contraception. Furthermore, many teens interviewed at the clinic before seeing the clinician expressed a great deal of apprehension about the pelvic examination. They were afraid it would hurt or that they would be embarrassed. Many teenagers were also unaware of the purpose and procedures of the exam, including what a speculum is and how it is used. If these fears were expressed by those who had mustered the courage to get as far as the clinic waiting room, how much greater must be the fears and ignorance of those who never come?

  Finally, and perhaps most important, even in those study areas where parental consent was not required, many teenagers did not know that they could legally request family planning services without such consent. Furthermore, many teens were not aware that services were available to them at little or no cost.

II. CLINIC POLICIES AND PROCEDURES

A. Initial Teen Access

In the course of the study team's interviews and clinic observations, it became apparent that three threshold conditions exist which clinics must meet if they are to attract the greatest number of teenage patients: (1) they must make sure their services are known to teenagers; (2) they must guarantee the confidentiality and anonymity of the patient visit; and (3) they must be affordable. Other factors enhance or inhibit teen access to services, but these three are crucial.

The conclusions in this section deal with aspects of clinic operations and procedures affecting these three conditions.

9. Publicity efforts geared to teenagers are inadequate.

Only two programs (both large metropolitan Planned Parenthoods) conducted major publicity campaigns aimed at teenagers. Over half the programs studied (mostly health departments and hospitals) did not publicize their programs at all; those that did (mostly single-purpose agencies) mounted rather limited campaigns, usually directed to the general population of women rather than to teenagers specifically. Among the reasons given for not publicizing services to teens were the desire to maintain a low profile in order not to incur potential parental disfavor; pressure by local government (on public agencies only) to downplay the fact that they were supporting birth control for teenagers; and an inability to handle any more patients.

Among the publicity methods some clinics used were flyers, posters, newspaper ads (including ads in high school papers), bus and subway advertising, and teenage telephone "hotlines". Some programs had sponsored public service announcements on radio and TV; others made efforts to educate local disc jockeys with large teenage audiences on the need for birth control among teens, in the hope that they would include such issues in their programming.

The only available feedback on the effectiveness of this publicity was in the case of the subway and bus placards and the teen hotline, which the sponsoring agencies reported had substantially increased their calls from teenagers. One example of the effect of "inadvertent" publicity occurred when an agency in a small community requested local revenue sharing funds for teenage services, stimulating vehement opposition on the part of the local governing board. The publicity from the public uproar that ensued produced a substantial increase in the number of teen patients at the clinic--who presumably had been previously unaware that it was available to them.

In its teen interviews, the study team learned that the most effective and trusted means of publicity is word of mouth; friends were most often cited as sources of information on the clinics. In the final analysis, major publicity campaigns may only need to be of short duration, and only for newly formed clinics or those tucked away in larger agencies--just enough for word of mouth to get started. Advertising its phone number as a referral source rather than publicizing its services per se was a way one clinic got the word out without unduly arousing the public.

10. Outreach efforts by family planning clinics vary tremendously from program to program; the major deterrent to more ambitious outreach is resistance (actual or anticipated) from schools and the community.

The degree to which programs "reach out" to recruit teenage patients varies tremendously among programs. Most outreach activity for teens is necessarily directed at local junior and senior high schools in the community, and in fact, 37 out of the 40 programs in the study (80%) had some kind of liaison with high schools--ranging from maintaining informal referral liaison with school nurses or counselors to sponsoring comprehensive sex education courses and teacher training programs. Almost half the programs in the study provided speakers to local schools from a volunteer speakers' bureau.

In addition, about one third of the programs conducted teen outreach activities outside the school setting, in agencies such as local youth groups, service clubs, orphanages, homes for the retarded and juvenile detention homes. In some cases

providers conducted formal educational programs in these settings; in others, liaison was primarily through referral relationships.

The study team observed some very innovative and extensive outreach programs, including:

- A teen theater group where interested teens wrote a play around a teen sexuality theme, and performed it for community groups.
- Production of a closed-circuit TV program in sex education for the local high school.
- Development of a three-pronged sex education program for teachers, parents, and students which eventually became a federally financed demonstration project.

Unfortunately, a large portion (almost two-thirds) of the study programs devoted very little attention and staff effort to reaching teenage patients. Only fourteen programs, representing all types of providers, had full-time teen outreach workers and only about a third of the programs sponsored extensive outreach activities, mostly on-going sex education programs in local high schools. The providers identified the purpose of these efforts as general community or teen education, rather than teen patient recruitment. The reasons for this designation are twofold: (1) There is a traditional problem in the family planning field with evaluating the impact of outreach programs in recruiting patients, and (2) many agencies hesitate to publicize their teenage services in the community at large, especially in high schools (which, in fact, frequently prevent them from even setting foot on the premises), in order not to arouse negative reactions from the community, which is often quite ambivalent in its attitudes toward teenage sexuality and teen birth control services.

11. Clinics are not sufficiently aware of teenagers' needs for confidentiality.

"Fear of parents finding out" was mentioned as a barrier to using a family planning clinic more often than any other deterrent, and almost as often by the "non-user" as by the "user" teens. There is a desire, even on the part of teenagers whose parents know they are sexually active, not to "keep reminding them" of the fact.

The primary example of not keeping teenagers' visits confidential is the requirement for parental consent. In two study areas, parental consent was required: in one, teens under 18 who were single and not previously pregnant had to have consent forms signed by their parents; in another, all teenagers 14 and under needed parental consent. In the first study area, the proportion of teens served was relatively small compared to other areas--teens under 18 made up from five percent to 15% of the patient load in these programs, compared to an average of eight percent to 45% in programs in other areas. Also, most of the teens served in these programs were either married or had already been pregnant, and thus did not need parental consent. These teens, in other words, already had achieved emancipated status and were in a sense "beyond" parental consent. Left unserved in these areas were the many sexually active teenagers who are not married, had not been pregnant, and would not forge their parents' signature on a consent form.

Another area where confidentiality can be breached concerns how clinics handle patient information, aside from any parental consent requirements--and here most clinics had good records. Sixty-one percent of the clinics not only protected their patients' confidentiality, but made a point of letting their patients know it--a critical practice if the clinic intends to attract teenagers. Thirteen percent of the clinics protected patient confidentiality, but did not inform them of this fact--and 25% had practices which conceivably could breach confidentiality (these practices were found in hospital programs and a few health departments). With one exception, none of the programs where confidentiality was frequently violated attracted large numbers of teen patients.

Various clinic practices assured confidentiality: in one clinic only the patient's first name and a number were recorded on her chart; a card with her full name and phone number was sealed in an envelope to be opened only in an emergency. Many clinics asked their patients if they objected to being contacted at home, and if so, noted the objection in red ink on the patient's chart. Several clinics asked for a friend's phone number or address where the teen could be contacted if necessary. One clinic set up an alternative method (with the patient's permission) of using the school nurse as a contact.

Most instances of breached confidentiality occurred as a result of the clinic contacting the teen patient's home without her foreknowledge or permission. For

example, some clinics mailed appointment reminders, lab test results or bills for services to patients' homes. In other instances, clinic personnel telephoned the patient's home and identified themselves to whomever answered (which resulted in one patient's aunt receiving the results of her pregnancy test). Teenagers were unanimous in resenting these intrusions on their privacy, especially younger teens, who were the most fearful of their parents finding out.

Finally, clinic location plays an important role in protecting confidentiality, particularly in protecting the anonymity of the teenager's visit. The study team discerned a number of trade-offs in teenagers' views as to the best location for a clinic. On the one hand, teenagers find it difficult in terms of time and money to get to clinics located far away. On the other hand, teenagers will not go to a clinic in a highly observable or "visible" location, where peers or parents' friends might see them enter. In many instances, teenagers will trade convenience for anonymity. For example, the ultimate in convenience would seem to be a clinic located right in a high school. The study team visited such a clinic which had been set up as the result of a poll in which 85% of the student body favored the idea. Few actually used it, however, because it was held at a time and place that made anyone using it extremely visible. In another instance, a clinic originally located two blocks from a suburban high school was moved the distance of a 20-minute bus ride away. Teen patients interviewed there complained that it was "too far away," but the clinic reported that its teenage patient population increased substantially at its new location. In fact, at least one teenager in the study reported traveling at least an hour each way to a distant clinic, rather than use a more accessible (and public) facility.

First-hand data on the extent to which the lack of anonymity inhibits teen attendance at clinics was not available since the team talked to teens who were either already in a clinic setting, or already pregnant (the "non-users"). However, the numerous second-hand reports collected point towards the importance of a clinic's location in protecting anonymity. Furthermore, the young teens responding to the question of "where they would like a clinic to be located" indicated their preference for a location "farther away so there's not much chance of running into people I know." The team feels that this factor is of great

importance, particularly in reaching young teens. The ideal arrangement, from the point of view of both confidentiality and convenience, seems to be a family planning clinic located in any kind of a large, nearby facility--one the teenager could conceivably be visiting for reasons other than to get birth control or other sex-related services, such as V.D. or Maternal & Child Health Care (MCH) services.

12. The requirement of fees inhibits a substantial number of teenagers from seeking family planning services.

Twenty-five of the 40 providers in the study sample offered free services to teenagers. The remaining 15 charged teens for services in a variety of ways: five charged a nominal flat fee ranging from two to six dollars a year; four programs operated on a fee-for-service basis, charging from eight dollars to $15 for the basic lab test and exam; six programs used a sliding scale for teens ranging from nothing at all to $25. (Sliding scale refers to a system in which patient fees are set according to the patient's ability to pay. Generally, nominal or no fees are charged those with little ability to pay, with fees increasing proportionate to patient's income level.)

The message from the teen interviews is clear: the higher the cost, and the larger the lump-sum payment required (that is, when there is no deferred payment plan), the greater the obstacles to teenagers--and this includes teens from the rural and more affluent suburban areas as well as the less affluent urban teens. This finding supports other studies which have shown that even teens from middle- and upper-income families can't always acquire enough money to pay for family planning services if they choose not to tell their parents what they are doing. "Money problems" were cited often by teens queried at clinics charging high fees. Many patients in free or low-cost clinics reported that not having to pay (or pay much) was a prerequisite to choosing that particular clinic. Indeed, two patients had traveled over an hour by public transportation to reach a free county hospital rather than go to a fee-for-service clinic they knew existed closer to home. In fact, teenagers will suffer long waits and impersonal service (two aspects of clinic operations that they find especially unpleasant) in order to get free or low-cost care.

Most clinics that charged patient fees but offered deferred payment did not publicize this policy very widely. Thus, it is probable that many teenagers

who would have taken advantage of a reduced or deferred payment policy were deterred from using these clinics because they expected a fee they could not afford.

B. Secondary Barriers to Initial Access

Once the three threshold conditions are met, other aspects of clinic policies and procedures affect initial teen access to a lesser degree.

13. Teenagers are discouraged from attending clinics by the prospect of long waits for an appointment.

Because a teenager's decision to seek contraception is often difficult, and one that is often put off for a long time after the initiation of sexual intercourse, it is important that clinics respond to a request for service quickly. Most of the study clinics (33, or 82%) required patients to make appointments for service. The wait at these clinics ranged from immediate service to four-weeks, with an average wait of 12 days. In many cases "drop-in" patients were accommodated whenever possible. Seventeen clinics requiring appointments scheduled all patients to arrive at the same time for any given clinic session. The remaining 16 staggered appointments by, for example, scheduling four patients every 30 minutes. These 16 clinics had a shorter wait for appointment (an average of nine days) than those clinics not using such a system (an average of 14 days). An additional interesting finding was that teen-only clinics also had a shorter appointment wait time (an average of nine days) when compared with integrated clinics (an average of 15 days).

Only seven clinics (17% of the study sample) scheduled sessions where patients dropped in without an appointment.

The teenagers in the study had few complaints if they had to wait one week or less for a clinic appointment. Eighty percent of the teenagers indicated that a wait of one week was satisfactory; however, 60% felt that a wait of over two weeks was "much too long."

Additionally, teenagers clearly preferred appointments over "drop-in" scheduling: 43% preferred an appointment, 25% said it didn't matter, and 26% preferred the drop-in system. The teen preference for appointments over drop-in sessions runs contrary to the philosophy of some drop-in clinics, which holds that these unscheduled sessions fit in with a teenager's rather impulsive, unplanned lifestyle. In fact, the study team discovered that both clinic personnel and teenagers have negative views of drop-in sessions, although for different reasons. Most providers regard drop-in clinics as unmanageable, with an unpredictable patient load that can result in either overcrowding or wasteful under-utilization--as, for example, during those times when a doctor is or hand with no patients to see. Teenagers, for their part, associate drop-in clinics with crowds, long waits, and a longer total time to be serviced or processed through the clinic--an assumption which the study findings bore out. Teenagers see appointments as a way of avoiding these disadvantages.

The study team believes that the shorter the appointment wait, the better for all concerned. Most important, given the fact that almost all the teens seen at the clinics have been sexually active long before they came to the clinic, each day they must wait for an appointment increases the chance of their becoming pregnant. Furthermore, clinic personnel reported an increase in the incidence of "no-shows" among teens who had to wait a week or longer for an appointment.

14. <u>The ability to get a pregnancy test quickly and at little cost will draw many teenagers to family planning clinics.</u>

Clinic staff estimate that as many as half of their patients first come to clinics as the result of a pregnancy scare. Furthermore, it appears that teens who come with that fear, but who prove <u>not</u> to be pregnant, are especially receptive to becoming conscientious users of birth control. Almost all the clinics (90%) in the study did offer pregnancy testing--but <u>it was not always available to new patients</u>, due to the clinics' confusion as to what services the Title X guidelines legally permitted them to offer to first-time patients. In some cases, first-time teen patients requesting pregnancy tests were turned away, or referred to other sources--a prime example, in the study team's opinion, of fragmenting services and missing a good opportunity to recruit new teen patients.

15. With the significant exception of younger and Latina and Asian teens, most teenagers do not necessarily prefer "teen-only" clinics per se. However, teen-only clinics make it easier FOR THE PROVIDER to provide services of a kind and in a manner that teenagers like.

Half the clinics in the study had established teen-only sessions--clinic sessions serving only teenagers, to the exclusion of adult women. Teen-only clinics appeared in every type of program in the study sample and in programs of all sizes. Only two of the study areas did not have such sessions. The team was surprised to learn that so many (36%) of the health departments operated teen-only sessions--and so few, relatively speaking (50%) of the Planned Parenthoods did, considering the fact that Planned Parenthood pioneered the teen clinic concept in San Francisco during the late 1960's.

Administrators at those clinics which did not have teen-only sessions usually felt that such special sessions were not warranted in order to serve teenage patients adequately: "We treat teens like adults; they shouldn't and don't want to be labeled as 'different,'" was the tenor of this argument. And in fact most teens, when asked specifically, did not seem to prefer these clinics--with the significant exception of teens 14 and younger, and the small number of Asian and Latina teens in the study. The growing number of sexually active teenagers 14 and younger, however, suggests that their preference for teen-only clinics is well worth taking seriously. And indeed teen-only clinics did serve a younger clientele than the integrated clinics: in teen-only clinics the median percent of young teens (15 and under) was 14; in integrated clinics the median percent was four.

Furthermore, teen-only clinics were able to provide two of the most desirable features for their teen patients: they were more likely to be free or low-cost than integrated clinics (see TABLE 8), and they generally had a shorter waiting time for appointments (nine days, compared with an average wait of 14 days in integrated clinics).

TABLE 8
TYPE OF DELIVERY APPROACH AND CLINIC FEES

Type of Delivery Approach	CLINIC FEE				
	# of Clinics With No Charge	# of Clinics With Some Fee	If fee, cost to teen patient		
			Low	Med	High
Teen-Only	12 (63%)	7 (37%)	4 (57%)	2 (29%)	1 (14%)
Integrated	13 (62%)	8 (48%)	----	4 (50%)	4 (50%)

16. Clinic sessions scheduled in the late afternoon and early evening are most convenient for teenagers--primarily to protect confidentiality.

Seventy-one percent of the clinics in the study offered clinic sessions during late afternoon and early evening hours, times their teen patients rated "convenient." Twenty-five percent of the clinics, however, scheduled sessions only during the morning and early afternoon hours. Two programs held evening clinics which often required patients to stay after nine o'clock, and at one of them the team observed two patients leave before receiving a birth control method because they had to get home. In general, teens queried at the morning, early afternoon, and late evening clinics said that "It's hard to get away from home for so many hours" (13%), and "It's hard to get out of school to come here" (15%). Behind these responses were (a) having to let their parents know where they were if they were not home during the late evening hours, and (b) problems in getting excused from school (or admitting the reason for needing the excuse) for morning and early afternoon sessions.

17. Clinic location can deter teen patients if it is too far away or hard to find.

Seventy-six percent of the clinics in the study--generally those in urban areas-- were near public transportation; some were within easy walking distance of high schools and neighborhoods where the teenagers lived. Twenty-three percent--all in suburban and rural areas--required a car to reach. Still, 14% of the teens queried reported transportation problems: 15% of the urban teens, 17% of rural teens, and only seven percent of the suburban teens. The specific transportation issues most often raised were the amount of time and money it took to get to the clinic by pbulic transportation.

Another problem raised by the teens was the difficulty they experienced in finding the clinic. In two cases the clinic's sign was not visible from the street, but in the majority of the cases (43% of the clinics) the problem was one of finding the clinic in a larger facility. Teens reported that in large facilities there were no clear signs to direct them to the right room. At one of the hospital-based programs (which were in general the hardest to locate) a teenager said she was embarrassed at having to ask three people "where the birth control place was." In one large county hospital the family planning staff remedied this problem by taking the time to analyze the logistics of locating their clinic from the patient's perspective, and then placing attractive posters at each main hospital entrance to show the clinic location.

18. The longer and more complicated the admissions procedures, the less teenagers will use a clinic.

With the exception of hospital-based programs, being admitted to a family planning clinic was fairly simple and quick for teen patients, and in general posed no problem for them. For many of the hospital programs, however, family planning patients had to go through the rather elaborate regular hospital admissions procedures--and at two clinics teenagers had to complete these procedures prior to the day of their clinic visit. These clinics had a lower proportion of teenage patients than did the clinics with simpler means of entry. Several of the teens at one clinic said that it took them three hours to go through these procedures. On the other hand, one county hospital made it easier for family planning patients by giving them a special admission card, thus by-passing the hospital bureaucracy.

19. While teenagers like clinics to be clean and orderly, they do not rate "teen-oriented decor" as very important.

The study team found over half the clinics in the study to have very attractive physical environments; for the most part, they were located in relatively new buildings, or in converted facilities such as stores, churches, and super-markets. The rest of the clinics had adequate physical facilities, mostly in older institutional buildings. Over half the clinic facilities--and not always the newer ones--were warm and inviting, with plants, colorful and educational posters, and in one case an aquarium. Two exemplary settings posted pictures of the staff with their names underneath, and had posters

on such issues as the nutritional effects of birth control pills, and signs saying "You are welcome here" and "We want your suggestions to improve the clinic."

Very few programs, including the teen-only clinics, had teen-oriented decor, nor did teens rate this as something they thought was important. By teen-oriented decor is meant a setting which is specifically designed with teenagers in mind--for example, pillows on the floor for seating rather than chairs, rock music in the background, and psychedelic posters. What teenagers said they were more concerned about was a clinic that was clean and orderly, giving the impression that the people there knew what they were doing. Cleanliness is highly important to them: many teens, in deprecating free clinics, imagined that they were probably dirty or "grubby," indications to them that the medical care might not be trustworthy.

C. Continuing Teen Access

A teenager's initial visit to a family planning clinic represents the first step in what is supposed to be a continuing process of contraceptive care. Many patients, however, fail to return to the clinic after the first or second visit--thereby increasing the risk of unplanned pregnancy and endangering their health if contraceptive side effects are unattended. Some reasons for this drop-out rate are external to the clinic: teenagers move away, become pregnant (intentionally or accidentally), or decide to use "drug store methods" such as condoms or spermicidal foams. However, based on interviews with the "non-users," and with teens who had switched clinics, the study team learned that there were many aspects of clinics which teenagers didn't like--enough to cause them to change clinics or stop going altogether. Acting on the hypothesis that a teen's satisfaction with a clinic is a major determinant in whether or not she keeps coming back, the study team isolated three factors most important to teens' satisfaction with a clinic. They are:

(1) how they are treated by the clinic staff; (2) how they are treated by the attending clinician (physician or nurse practitioner); and (3) the clinic's efficiency in processing patients. The following conclusions explore factors affecting teens' satisfaction with clinic services and practices which influence their continuing attendance.

20 Teenagers need nonclinician staff members who will give them warm and personalized service.

The character of the interaction with staff was the single most important aspect of the clinic experience for almost all teens completing questionnaires: 75% of the teen patients and 60% of the "non-user" group said it was "very important" for the clinic staff to be "warm and accepting" of teenagers. When asked what they liked best about the clinic, teen "users" mentioned "the staff" more than anything else--using terms like "helpful," "respectful," "understanding," "concerned," "warm," and "interested." One teenager summed it up: "They treat you like people, not patients."

By the same token the staff figured prominently in unpleasant clinic experiences. Teens in the study most often cited unfavorable treatment by staff as the reason for not going to particular clinics. "They treat you like a number" was a common criticism of clinics unpopular with teens.

The team observed many instances where teens put up with incredible inconvenience, long waits, confusing patient flow, and drafty exam rooms--and still liked the clinic if they had established rapport with even one staff member. The importance of this interpersonal aspect of service, however, was not acknowledged by most service providers in the study clinics; whether it existed or not seemed mostly a matter of chance.

21. While there were many instances of egregiously thoughtless and demeaning behavior towards teenagers, most nonclinician staff treated teenagers pleasantly--but patronizingly. Many seemed unaware of teenagers' special needs.

The study team was frequently struck with examples of thoughtful behavior of the nonclinician staff:

- Bending policies when the situation demanded it. Many clinics deferred or eliminated drawing a blood sample for the VDRL if the patient felt extremely anxious or squeamish about it. A few clinics offered a patient her choice of a female clinician if they thought it would ease her fear of the pelvic exam. Some clinicians were willing to defer an exam if it proved too frightening or painful, while providing enough birth control pills to use until the exam could be completed.
- Taking pains to personalize treatment. Small gestures often made a difference: many staff established eye contact, smiled, found out how the patient preferred to be addressed, and took time to make the patient feel comfortable by asking about her school or future plans.
- Eliciting information in a nonthreatening manner. Many interviewers were able successfully to elicit information of a potentially sensitive nature such as past abortion history. They did this by clearly communicating an unbiased attitude about the subject, with the option made explicit to the teenager not to discuss the subject.

Unfortunately, the study team also observed a number of instances of needlessly demeaning behavior toward teens:

- Reprimanding teenagers loudly for not following clinic rules.
- Insisting on time-clock precision. One teenager who arrived before the clinic opened was told to come back later. Upon her return, five minutes after the admission process closed, the receptionist told her she was too late, even though she recognized her from before.

- Loudly calling a teenager's name in front of a group of other patients, or calling for the next patient from behind a door or from another room. Such public or disembodied summonses embarrass and confuse teenage patients.

For the most part, however, negative behavior towards teenagers was thoughtless, giving little indication that the staff member was aware of the patient both as a person and as a teen with special needs. Taking a blood test without bothering to look up at the patient, for example, or not smiling, or speaking in a distant and domineering tone of voice--these irritate people of all ages, but they have an especially negative impact on teenagers who have more than their share of misgivings about being at a birth control clinic in the first place.

When staff members did try to adopt a special attitude towards teenagers, it was more likely than not to be patronizing--"be sure to take your pills every day" spoken in a tone of voice that sounded like a pat on the head, a tone that teenagers are quick to resent.

At the same time, teens have special needs and fears that all too often went unsolicited or unacknowledged. When one interviewer asked a teen visibly shaking from fright if she was nervous, the girl said she was. "Don't be," said the interviewer, and left it at that. In another example, inflexible clinic rules prevented greater sensitivity. A girl had voiced considerable apprehension in a group session upon hearing of the rectal part of the exam. She was advised to tell the doctor of her fears, but was told that it was an absolutely necessary part of the exam.

22. Teenagers appreciate being told what is going to happen to them at the clinic, and the purpose of the various parts of the treatment.

Seventy-five percent of the clinics in the study provided some sort of orientation to the clinic visit, usually a brief description of the various stages of the clinic session and an explanation of the pelvic exam. Only two programs oriented patients completely to the lab work by explaining what tests would be done and why they were necessary. These two programs also made a point to inform patients of their rights to information and to ask questions about procedures.

Only six clinics (15% of the study sample) gave patients a full explanation of lab work and pelvic exam procedures, as well as complete feedback on both. Almost half the clinics reported some lab results to their patients, although usually only the blood pressure readings.

Teenagers in general appreciate being told what is going on to avoid being embarrassed by not knowing what to do next or where to go. The study team noted many instances in which teens--having no idea of what was expected of them during the visit--ended up being shouted at and herded around. They clearly found these treatments demeaning. Furthermore, in the opinion of the study team, the more the teenage patient is involved as an intelligent participant in the clinic visit and is told the reasons for various procedures, the more she will feel respected as a person capable of making her own decisions, and the more she will begin to accept responsibility for her own body and sexuality.

23. Lack of processing continuity and narrowly defined staff roles lead to both patient and staff dissatisfaction.

The study team observed that clinics were better able to establish personal relationships with their patients if they arranged for some continuity of clinic personnel with each teen. Some clinics, for example, made sure that the same person conducted the pre- and post-exam interviews. In another case, a clinic employed interviewers who doubled as school outreach personnel; each patient was assigned to the interviewer who was responsible for her particular school. Another clinic saw to it that a patient was treated by the same nurse practitioner at every return visit. Perhaps the most extensive example of personalizing treatment through staffing patterns was the clinic that had a "patient advocate" system, in which one staff member carried out all clinic procedures for any given patient.

On the other hand, the team found that the more rigid and limited the job duties of clinic staff having contact with patients, the less likely those staff members were to be understanding and pleasant to their patients. In seven of the clinics, medical aides (responsible for assisting during the exam and in some cases for instructing the patient on how to prepare for the medical exam) were curt and short-tempered with their patients. The majority of these instances were observed at clinics in hospitals or health departments where the medical aide was at the bottom of a rigid hierarchy and was limited to performing rather custodial duties:

changing the cover sheet on the examination table, disposing of patient drapes, showing the patient where to put her clothes, and removing the used medical instruments.

In clinics where the job of the medical aide was not so limited, the aides tended to be more helpful to the patients--presumably because they found their work more interesting and rewarding. In one clinic, the aide spent most of her time answering patient questions; at another, the aide took the time before the doctor arrived to brief the patient on what to expect, show her the speculum, and instruct her in the breast self-exam.

24. Clinics are using their highly qualified staff inefficiently to provide their family planning service.

The team came to this conclusion after observing many clinics where volunteers and other staff successfully performed clinic duties traditionally reserved for more highly trained professionals (such as public health nurses, registered nurses or social workers with a master's degree). For example, persons with a bachelor's degree, no degree at all, or licensed vocational nurses were observed conducting group educational sessions and raps, individual patient interviewing and education, and simple laboratory procedures. It seems evident that clinics are able to train and orient such workers to function adequately in these capacities. In addition, both nurses and family planning specialists* were seen to operate very effectively as clinicians, given the proper training and supervision.

However, the use of such "non-traditional" workers in clinics was overall quite limited. Only 11 or 27% of the study clinics used volunteers to service patients, while an additional 15 clinics used volunteers in less responsible functions--primarily as clerks. And only 9 programs or 22% of the study sample used non-M.D. clinicians extensively. Most hospitals and health departments in the study, along with most large providers of any type were likely to use traditional clinic staffing--employing public health nurses, registered nurses, or social workers to conduct patient interviewing and education, and relying mostly on M.D.s as clinicians.

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*"Family Planning Specialist" refers to any person who is not a nurse or a doctor and has been trained to function as a clinician. Such workers are legally employed in two of the study areas, where their functioning is regulated by state Departments of Health.

Many clinics could be using their staff more efficiently. Highly qualified nurses and social workers could function in supervisory and coordinative roles, rather than performing tasks which volunteers and less qualified professionals could be trained to perform. And clinics could increase their use of properly trained and supervised nurse midwives, nurse practitioners and family planning specialists as clinicians. Teenagers themselves seem to be much less concerned with the professional qualifications or training of staff than with their responsiveness and general competence (see below).

25. Teenagers need the clinicians who carry out the examination to be gentle and understanding, and to explain the examination as it proceeds. Sex, age, and qualifications of the clinician are less important.

To teenagers, the physical examination--and especially the pelvic portion of that exam--is the "main event" of their clinic visit. "Fear of the pelvic exam" was the second most critical obstacle to teenage use of a clinic, second only to their fear of their parents' finding out they were using a clinic. Not so surprising, then, is the fact that 80% of the "users" and 74% of the "non-users" reported that a "gentle and understanding" doctor was a "very important" feature of their clinic experience. And 75% of both "users" and "non-users" also expressed a strong preference that the clinician explain what s/he was doing during the physical examination.

Seventy-five percent of the clinicians the study team observed were doctors, and 25% were nurse practitioners. Almost half were female: all the nurse practitioners and half the physicians. Three-quarters of the programs had nurse practitioners on their staffs. In many cases, the nurse practitioner functioned in an equal capacity with the doctor on duty, or as the sole clinician, with a doctor on call for medical back-up. In other cases, a nurse practitioner examined returning patients with no special problems, while the doctor saw all new and "problem" returning patients.

Do teens prefer women clinicians? Some teens do, especially younger, Latina, and Asian teens--and there were many instances in which teens reported being less

"up-tight" when they found out the clinician would be a woman. Half the teens, however, responded that it didn't matter what sex the clinician was, but extremely few stated a preference for a male clinician. The particular profession--doctor or nurse practitioner--of the clinicians was rated unimportant by most teens. What they wanted was someone who knew what s/he was doing and would also be gentle, understanding, and tell the teen what was happening during the exam.

As it happened, however, women clinicians were rated higher than men on their pelvic exam technique and their manner in dealing with patients by both the study team and the teens themselves. The study team assigned a rating of low, medium, and high to clinicians based on how they conducted the exam (whether the clinician checked to see if the patient had had a pelvic exam before, explained procedures to the patient during the exam, was gentle, and gave the patient feedback) and their manner with the patient (whether s/he established rapport, helped the patient to relax, permitted her to discuss her concerns). The following table shows the results of this rating. In general, female clinicians and nurse practitioners rated highest.

TABLE 9
URSA CLINICIAN RATINGS BY CLINICIAN SEX AND PROFESSION*

URSA CLINICIAN RATINGS	CLINICIAN SEX		CLINICIAN PROFESSION	
	MALE	FEMALE	DOCTOR	NURSE PRACTITIONER
Low	10 (53%)	4 (22%)	13 (46%)	0
Medium	7 (37%)	2 (11%)	8 (29%)	1 (11%)
High	2 (11%)	12 (67%)	7 (25%)	8 (89%)

* The team was permitted to observe the clinician in only 37 clinics.

Teen evaluations (drawn from questionnaires in which they were asked to check one of the following: "I liked the doctor very much," "The doctor was OK," or "I didn't like the doctor very much") corresponded closely with the study team's ratings. Patients who were examined by women clinicians were twice as likely to say they liked the doctor "very much" than those seen by men. However, while teens did appreciate the simple fact of having a woman clinician in many cases, the strongest reason for their preference was the fact that the women clinicians talked to their patients more, acknowledged their fears of pain, and explained the results of the exam, if only to say, "Everything looks fine." Finally, women clinicians more often offered interested patients mirrors, speculums and stethoscopes to examine their own bodies. (Incidentally, with the exception of New York and the San Francisco Bay Area where the self-health movement is strong, a large portion of teenagers--45% of the "users," 34% of the "non-users"--did not express much interest in being offered a mirror to look at their vagina and cervix.) The age and "hipness" of the clinician, or whether or not s/he wore a white coat, was not deemed important by most teens, although younger teens did express a preference for young clinicians and white coats.

26. <u>The length of processing time is too long for most teen patients--especially for returning patients</u>.

A substantial number of teenagers felt that the amount of time spent at the clinic was excessive. Fifty percent of the teenagers who responded to the questionnaire said that they felt the time spent at the clinic was either "somewhat too long" or "much too long"--and returning patients who were at the clinic for a method check, supplies, or an annual check-up were twice as likely to find the time spent excessive. When asked what they liked <u>least</u> about the clinic, half of the teenage patients indicated that "the wait" was particularly aggravating.

Most teen patients (new and annual return patients)* spent just over two hours to get service; however, more than half this time was spent in <u>waiting</u>. The total time teens spent at the clinic ranged from 25 minutes to 260 minutes (four hours and 20 minutes), with a median total time of 129 minutes. Time spent in clinic

*The team observed and documented processing time on new patients only, or those returning for annual check-ups.

activity ranged from 20 to 130 minutes, with a median time of 54 minutes (15 of these minutes were spent with a clinician). The median wait time was 75 minutes. Thus, 55% of a patient's time at a clinic was spent in waiting. In comparing the teenagers' rating of time spent at the clinic as being "OK," "somewhat too long," or "much too long," with the actual time spent in clinic activity and time spent waiting, it appeared that teenagers are most concerned with the overall time they have to spend in the clinic. Whether this time is spent in clinic activity or "dead" waiting time is a lesser consideration.

The study team observed several practices which increased processing time:

- Drop-in clinics and clinics which scheduled all patients at the same time had long lines at registration and throughout the rest of the clinics.
- Two clinics which had staggered appointments in theory actually treated patients on a first-come basis. Knowing this, patients tended to show up at the beginning of the session regardless of their appointment time and consequently had to wait long periods for service.
- Many patients held things up because they weren't told where to go next or which waiting room to stay in; in those clinics that didn't permit smoking, patients would go outside to smoke while waiting their turn and then not get back in time or to the right place, or miss their turn altogether.
- The more steps included in clinic processing and the more staff people the teen patient saw, the greater the chance for confusion--and loss of time. There were instances in which a patient would interrupt a busy staff member to ask where to go next, while the staff person she was to see was sitting idle.
- A major bottleneck was the wait for the clinician. Patients were generally scheduled to be in the examining room well in advance of the clinician so the clinician wouldn't have to waste time waiting; also, many clinicians arrived late because of demands at their other jobs.

Among the practices the study team observed which expedited patient processing:

- Well organized, staggered appointment systems cut down on processing time, even when there was a group session. Patients liked it because they knew they were being taken "on time."
- In one clinic where a patient was led through the entire visit by a patient advocate, there was virtually no "dead" time since, once finished with registration, the patient never had to wait her turn. A patient advocate at this clinic could be a doctor, a nurse practitioner, or a family planning specialist; each was trained to perform all clinics functions, including the exam. Their patients, therefore, were never left wondering where to go next.

Processing time did not vary significantly among the different types of clinics, except for community hospitals which took longer to process their patients (a median time of 145 minutes, as compared with medians ranging from 120 to 128 for the other types of clinics).

D. Secondary Barriers to Continuing Access

Other aspects of clinic operations and procedures that affected whether or not teenagers were satisfied with, and continued to use, a clinic had to do with issues of privacy, clinic organization, and fee payment.

27. Teenagers, and especially young teenagers, need to have their privacy protected while at the clinic.

The study team found that clinic personnel are generally more sensitive to the teen's need for confidentiality about her visit than they are to her need for privacy once she is there. By privacy is meant the procedures at the clinic that insure both physical privacy of the patient and privacy of patient information within the clinic itself. The following examples illustrate the ways in which patient privacy was trespassed in the clinics in the study:

- Requesting personal information at the reception desk, where other waiting patients can hear. Teenagers are understandably reluctant, for instance, to announce in the waiting room or at a busy reception desk that they have come for a pregnancy test.

- Conducting interviews or counseling in the reception area or waiting room, or leaving doors to private counseling rooms open.
- Discussing patient histories within the hearing of other patients.
- Leaving patient charts where others can see them.
- Lack of facilities for dressing and undressing in private.
- Having more people than necessary in the examination room with the patient.
- Having patients carry urine specimens through the public waiting area.
- Having patients wait a long time while partially dressed, or having them walk through the clinic in the examination gown and bare feet.
- Requiring patients to reveal personal information to a number of people.

The study team documented the extent to which clinics respected patient privacy. Fourteen clinics (37% of the study sample) were observed to violate privacy in more than one way; nine clinics (24%) each had one practice which could violate privacy; and fifteen clinics (39%) exhibited no violations of privacy.

The study team found that, while the lack of privacy was not a primary deterrent to continuing teen use, teens are very sensitive to the issue and appreciate it when their privacy is protected. As with other issues involving the need for special treatment, the younger teens expressed a greater need for privacy than older teens.

28. Teens in the study have strong desires for the family planning service to be "well organized."

In rating the importance of various service aspects, teenagers overwhelmingly voted for a well organized clinic. Eighty-nine percent of the teenage patients and 81% of the "non-users" who completed the questionnaire said that it was "very important" for the clinic to be "well organized." The team

interprets this strong response to be related to two teenage concerns. First, in the team's interviews teenagers frequently equated quality care with a well organized, efficient clinic operation. If clinic personnel appeared to be professional, knowledgeable and "knew what they were doing," teenagers reacted favorably, feeling that they could trust the competence of the clinic staff. Most teens do not have either the experience or the knowledge to make sophisticated technical judgments about the competence of the clinician or staff; it is therefore likely that they are really talking about the extent to which the clinician's manner and the way the clinic is organized make them feel secure about the quality of care they are receiving.

Secondly, the team feels that a "well organized" clinic has the connotation for many teenagers of a service which is efficient and processes patients quickly, an important teenage concern discussed earlier.

29. Teenagers need the options of deferred payment plans and sliding-scale fees, although establishing a fair fee for teenagers can be difficult.

Almost as important as the fees themselves is the manner in which fee payment is presented to teen patients. Since many teenagers have limited access to money for clinic fees, it is important that they have the opportunity to pay their fees over time. Although numerous clinics permitted deferred payment, several did not inform their patients about it; in only two of these clinics did the study team observe that teen patients actually had an unbiased option to pay later. In the other clinics patients were informed of the option to pay later but were not encouraged to do so. In these instances, teenagers who would have truly benefited from a deferred payment system were often embarrassed to have to ask for it, feeling that they were requesting "charity," particularly the low-income patients most in need of deferred payment. In the two clinics which did openly offer their teen patients the opportunity to pay later, most eventually paid their full fee over time.

The question of using sliding scale payments is especially problematic for teen patients. It is difficult to establish a standardized yet equitable method of assessing a teenager's income since teenagers usually do not know how much income their family has, nor do they wish to ask their parents for such information if they prefer to keep their visit confidential. Thus, the teenage

client poses problems for clinics that desire to assess family income in order to determine an appropriate fee.

E. Encouraging Contraceptor Effectiveness

Initially attracting teens to family planning clinics, and keeping them as on-going clinic patients are necessary steps toward the primary goal of preventing unwanted pregnancies among teens. Clinics must also provide whatever counseling and education in birth control methods and sexuality teenagers need to become effective contraceptors. The task of clinics is threefold:

- to provide teenage patients with information on contraception and the proper use of various methods of birth control;
- to help teenagers select a method that is appropriate for them, considering their pattern of sexual activity, medical needs, aesthetic concerns, and social environment; and
- to help teenagers feel as comfortable as possible with contraceptive methods, and to provide instruction in and support for the teenager's own "method of choice"--to the extent this method does not violate the clinician's professional judgment.

As discussed earlier in this report, the incidence of prior pregnancies among clinic "users," and the fact that many of the "non-users" had visited clinics at one time indicate that the clinics in this study fall short of the mark in carrying out these responsibilities. The following conclusions center on aspects of clinic policies and procedures which hinder or enhance providers' ability to promote effective contraceptive use among their teenage patients.

30. Teenagers need information on ALL birth control methods; they prefer that information be transmitted in discussion (or "rap") sessions rather than in lectures.

The study team found that the method and content of patient education vary widely among the clinics in the sample. Many programs (27, or 67%) provided an educational session for their patients. Groups were usually mandatory, held on the same day as the clinic visit, and were for new patients only. (Only two programs held group sessions for returning patients.) Most of the sessions were conducted as lectures and entailed little, if any, group discussion. Six of the groups were "rap" sessions, in which "rap" leaders encouraged teens to talk about issues of importance to them. These issues included sex and sexuality, boyfriends and parents and their attitudes towards birth control, and fears and misconceptions concerning birth control and sex. Some sessions included a mix of lecture and discussion: the leader presented information on various topics, pausing to ask for questions. While this format did not stimulate lively discussions, it did help some patients' questions get answered.

All of the "rap" sessions were in the teen-only clinics; indeed, 84% of these clinics had some kind of group education. By contrast, less than half of the integrated clinics conducted group education sessions at all; when they did, the sessions were conducted as lectures, with little or no opportunity for discussion.

Without question, more teens preferred the "rap" sessions (62%) to the lecture format (9%). Among the reasons for this preference were:

- the chance to share feelings with other teens
- the ability to gear the discussion to what they wanted to know, and to ask questions
- the freedom to discuss sexual concerns openly, often exemplified by the group leader sharing some of her own experiences
- the support of the leader and of the group when voicing concerns and fears about sexuality.

Teenagers found the lecture format, on the other hand, too impersonal. They also frequently felt talked down to, and were often bored with the basic reproduction lecture which many had already heard at their high schools. Most of the lectures the team observed presented information on the major forms of birth control, but in most cases both the manner in which the information was presented and the range of content covered was judged to be inadequate. The content areas usually ignored were a discussion of withdrawal and the "safe" period, and a discussion of teenagers' concerns around sexuality and relationships. Teenagers frequently use withdrawal and "safe" periods as methods of birth control and will probably fall back on these methods if they experience any problems with the methods they receive at the clinics. By not discussing these two methods, the clinic leaves the teenager without adequate information to use them effectively, leaving her more at risk of future pregnancies. As for discussing sexuality, fully 65% of the teens said that getting information on sex at the clinic was either "important" or "very important," but they rarely got this information.

While the information about birth control methods presented by most clinics was very detailed, with a heavy emphasis on oral contraceptives, it was not organized in such a way as to help the teenager make a decision, or even to communicate to the teenager that such a decision was her responsibility to make. Most presentations were didactic descriptions of what each method is, and how it works. Information on the advantages and disadvantages of each method as they relate to one's particular situation--degree to which one is willing to risk pregnancy and frequency of sexual activity--was rarely included. As a result, teenagers tended to be bored and impatient. The study team feels that presenting information on various methods in a way that stresses the teenager's need to make her own decision will encourage her to take responsibility for herself and her sexuality.

31. Clinics do not conduct enough family planning counseling.

The purpose of family planning counseling is to help a patient choose a method of birth control appropriate to her condition and pattern of sexual activity, and to help the patient integrate the use of the method into her life. Only eight clinics (20% of the study sample, including all but one of the teen-only clinics) included family planning counseling as part of their services. In five other clinics sexual histories were routinely taken, but were not used

for counseling or any other purpose. In many cases clinic staff said they did not offer counseling because they felt teenagers did not want to discuss their private lives and feelings about sex with an adult, particularly a stranger. Their opinion was not borne out, however, by the teens themselves: 36% of the respondents said they would "like a clinic where someone gives me a chance to talk about my relationship with my boyfriend or my personal feelings about having sex." Another 35% said it didn't matter, and only 22% indicated they had a strong aversion to the idea.

32. Clinics do not include boyfriends sufficiently in the family planning process.

Fifty-seven percent of the patients completing the questionnaire thought it was "important" or "very important" to bring their partners to the clinics. Forty-five percent of "users" and "non-users" alike wanted clinics to "encourage guys to come to clinics with their girlfriends," compared to only 13% that preferred a women-only clinic (mostly very young teens who may still not be open about their sexual activity). In addition, many of the teens interviewed said that their boyfriends were sources of support for their use of birth control, and in some cases the decision to use birth control was described as a mutual one.

Nevertheless, attendance by boyfriends at the clinics in the study was low (although a number of patients reported that their boyfriends were either waiting outside in the car, or were coming back later to pick them up). Only one third of the 46 males contacted in clinic waiting rooms were invited by clinic personnel to participate in clinic activities--most of them in the group education sessions. Half sat in the waiting room doing nothing; 25% "read some literature." When asked why they had come, most (29, or 63%) said their girlfriends had asked them to, 14 (30%) said they came to provide transportation, three for counseling or supplies for themselves, seven to get information about birth control, and another seven to share in their girlfriends' experience.

Teens in the study indicated that they are influenced by their partners' feelings in their own use of birth control; these feelings are especially important when it comes to the use of condoms, spermicidal foams, diaphragms, rhythm and withdrawal. By not including boyfriends in the family planning process, clinics are ignoring

an important influence on teenage women as effective contraceptors. Equally as important, perhaps, they are lending support to the common notion that birth control is the woman's business.

That boyfriends need information on birth control is evident from their responses to the study team's questionnaires. Queried as to their feelings concerning condoms, 11 said they "feel OK about using them"--but 17 responded that "it's too much of a hassle to use them," and 15 indicated that they "can't feel much when they use them." Two men indicated that they didn't know where to get them, three felt that buying them was embarrassing or difficult, and four thought that having a condom would "make it look like I was planning to have sex with the girl." (No one indicated that they were too expensive, or that it was too embarrassing to put them on.)

For clinics to include boyfriends as part of the family planning process, they will have to take into account a number of attitudes reported by the men contacted by the study team at the clinics (which, presumably, only hint at the feelings of the men who do <u>not</u> attend). Most of the men responding to the questionnaire agreed that boyfriends should be included in family planning clinics, but only five out of the total 46 wanted to be included more. Less than half of the men felt completely comfortable being in a clinic, partly out of general embarrassment and a sense that they didn't belong there. Many felt that more boyfriends didn't come because they thought clinics were oriented primarily to females.

III. QUALITY OF SERVICES

Over 67% of the teenage patients in the study felt that they had received "good" or "excellent" medical care. However, on the basis of patient interviews, the study team concludes that most teenagers do not have a medically sophisticated concept of quality care--nor do they have technical knowledge about correct medical procedures.

On the basis of their observations of clinical practices in clinics in the study sample, the team feels that medical care and practices are often inadequate. The following conclusions deal with this issue.

33. Only 67% of the programs in the study performed all of the procedures that DHEW has set as minimum requirements for Title X grantees, despite the fact that 80% of the programs received Title X funds and 90% received some sort of public funding.

The laboratory screening procedures suggested by the DHEW medical guidelines are routine VDRL testing for syphilis, pap test for cervical cancer, hematocrit, urinanalysis, blood pressure, and height and weight measurements. The most frequently omitted service was the VDRL test for syphilis. Ten of the 40 programs provided this service only if the patient requested it, and for patients with positive gonorrhea tests; three programs did not offer the test at all.

Also, while breast exams were included along with the pelvic exam in almost all cases, only 24% of the clinics performed heart and lung exams, only 42% performed thyroid exams and only 39% performed rectal exams.

Only one program provided laboratory screening designed to identify "DES daughters," and only two other programs even asked patients about exposure to DES--even though the present teenage population comprises a large part of that group of women who may have been exposed to the drug DES (diethylstibestrol) in utero, and, therefore, are at a higher risk for vaginal cancer. Furthermore, some experts believe "DES daughters" may suffer complications if they use "combination" oral contraceptives.

All programs offered gonorrhea screening, and most offered screening for vaginitis. Three-quarters of the program offered sickle-cell anemia testing to their black patients, and 35% also provided screening for rubella.

34. Treatment for these conditions (though not a Title X requirement, nor indeed traditionally part of family planning per se) is more likely to be found in health departments and hospital programs than in other types of programs.

Eleven programs (28% of the sample) offered treatment for all of the following conditions: venereal disease, vaginitis, cervicitis, menstrual irregularities, anemia and cystitis. Twenty-nine percent of the programs, however, did not treat VD; 24% did not treat vaginitis ; 33% did not treat cervicitis; 42% did not treat menstrual irregularities; 45% did not treat anemia; and 61% did not treat cystitis.

Six of the programs (mostly Planned Parenthoods) offered early therapeutic abortion services to their patients; most of the hospital-based programs had abortion services available within the hospital.

35. In a few clinics, medical techniques are inadequate and numerous clinics are inadequately screening and treating patients.

In two instances, techniques used to insert IUDs were of questionable medical quality. In addition, the medical screening practices for determining contraindications to particular contraceptives and the existence of the side effects were often inadequate. In a number of the clinics the staff, including clinicians, lacked effective interviewing techniques. They were frequently unsuccessful in obtaining all of the information necessary to determine the appropriate birth control method for a patient. Contraindications to particular methods and various medical problems were often neglected due to an inability to conduct effective interviews, or in a few cases, to the fact that the clinician did not review the patient's medical history prior to prescribing a method.

There were other instances in which the staff responsible for obtaining the medical history or for conducting "rap" sessions failed to transmit medically relevant information to the clinician. In one example, a patient who was in the clinic for her annual visit mentioned during the "rap" session that she was concerned about a swelling under her armpit. However, not one staff person during the remainder of this patient's visit elicited this concern from her, nor was there any mechanism for the "rap" group leader to note and communicate this concern to other clinic staff.

36. Within many clinics there are discrepancies among clinicians in the services and procedures they carry out.

In many clinics medical protocols either did not exist or were not enforced. Clinicians in those clinics often varied greatly in the procedures they performed and in the approach they took to prescribing contraceptive methods. For instance, one clinician in a clinic might routinely perform a thyroid exam, while another clinician in the same program might not; or one clinician might not prescribe an IUD for a teenager unless she had been pregnant in the past, while another might prescribe from the full range of methods.

37. The IUD is the only form of birth control which is inconsistently available to teenagers.

Most programs offered teenagers the standard array of methods: pills, diaphragms, foam, and condoms. Only the IUD was not always available. Three programs did not offer IUDs to teens at all. Four programs had some restrictions on its use for teenagers. In one, parental consent was required; in the other three, IUDs were inserted only in teenagers who had had a prior pregnancy. Reasons given for restricting or prohibiting the use of IUDs for teenagers had to do with both a medical reluctance to insert IUDs in any woman who was not previously pregnant, and a legal reluctance to insert IUDs in minors who did not wish to involve their parents.

IV. EXTERNAL CONSTRAINTS

In all of the study areas, three forces external to the family planning clinics themselves limit teenagers' access to birth control: state and local laws governing the treatment of minors, federal policies governing the level and method of support for family planning, and community attitudes towards premarital teenage sex and teenagers' right to birth control. The following conclusions deal with these external contraints.

A. Restrictive Legislation

38. While the rights of minors to obtain birth control without parental consent continue to expand, these rights are not yet extended equally to all minors, nor do they exist in all states.

At the time of this study 23 states had granted young people under the age of 18 the right to consent to birth control services without parental consent; in the remaining 27 states parental consent was still required.

The eight study areas are somewhat more liberal than the nation as a whole. In more than half of them, specific enabling legislation exists that permits the teenager to be served without parental consent. Two study areas, while not having specific enabling legislation, have sufficiently favorable departmental requirements and court decisions so that clinics feel secure in providing birth control without parental consent to some groups of teenagers. In one study area, all teenagers were required to have a parental consent form signed to get birth control--unless they were emancipated by marriage or a previous pregnancy.

However, in many instances young teenagers, 14 years and under, are frequently denied the right to consent to their own care, even in those states which have specific enabling legislation. For example, in one state (prior to recent legislation) only those minors 15 years and older could consent to their own contraceptive care; and in another state, teens under 14 still have to have parental consent. Thus, the group most often needing parental consent (the very young single adolescents from 11 to 14 years old) is the group which is both most fearful of parents "finding out" and

at gravest risk of serious consequences to themselves and their child if they do become pregnant.

39. For a variety of reasons, many family planning programs adopt policies for teenage patients which are more restrictive than the law requires.

The legal situation in the one study area requiring parental consent for all unemancipated minors illustrates the conflicts that lead clinics to protect themselves with such requirements. In this study area, a state statute requires parental consent for a minor to receive medical care, and the state Department of Health's guidelines advise serving unmarried minors only with parental consent. On the other hand, the state Department of Welfare's policies for providers receiving Title IV-A funds (prior to Title XX) specifically state unmarried minors can be served without parental consent. The clinics' response to this ambiguous situation is to protect themselves by requiring teens to bring a consent form signed by their parents--although the signatures are never verified by the clinics.

Even in those study areas where the legal situation concerning service to teens was clear, clinics still had policies to protect themselves and their physicians against possible community pressure and malpractice suits:

- Restrictions against prescribing IUDs to teens. Seven programs in the study had such restrictions, and in four of them the reasons were primarily legal: insertion of an IUD is considered a surgical procedure (in some states), qualitatively different from prescribing pills or a diaphragm, and one which could expose the physician to the threat of malpractice suits. Also, clinics fear that, should any major medical complications arise, teenagers' parents would have to be informed to consent and/or pay for necessary treatment. The result of these restrictions is to limit teenagers' access to using the IUD, not on the basis of medical considerations but solely because of the teenagers' legal status as a minor.
- Restrictions against non-physician clinicians treating teens. Five programs in the study required teen patients to see a physician rather than a nurse practitioner (out of a total of 11 programs that employed both types of clinicians), on the grounds that teens may require more advanced medical assessments than older women. The reasons for this policy, however,

stemmed more from a wish to protect their legal position than to provide appropriate medical care. In many states the legality of using a nurse practitioner to perform what traditionally have been duties of a physician has not been clearly defined. When this uncertainty is combined with the uncertainty concerning service to teens, the clinics' response is to protect their legal liability by directing all teen patients to a physician who is therefore often overloaded with patients. In the clinics with this policy, teenagers had to wait long periods to be examined by the physician and in some cases even had to return a second time.

- Required "cooling off" periods for teen patients. One clinic, at the instigation of its advisory board, required a teen patient to visit the clinic first for an extensive counseling session and then, when she was "sure she had thought it over clearly," to come back a second time to be treated. There were other clinics that used this procedure for other reasons, but in this case the motivation was clearly the clinic's wariness of the legal implications of serving teens.

- Refusals of physicians to treat teenagers. The study team observed physicians who refused to treat teens without parental consent, even if the clinic did not require it--and in some cases would not treat a teenager even with parental consent. This occurred at three of the five rural clinics in the study. It is indeed a special problem for clinics in the rural areas which, because of the scarcity of physicians, must sometimes hire physicians who will not serve teens.

To sum up, despite the liberalization of laws concerning the right of teenagers to consent to their own medical care, a teen's legal status as a minor is still a big obstacle to obtaining contraception. Even in areas which have clear enabling legislation, the clinic is still faced with their clinicians' fears concerning their own legal liability regarding malpractice suits and serving teenagers in general. Furthermore, many agencies lack a detailed knowledge of state statutes and pertinent departmental policies which affect their legal situation. They also lack information on those clinic policies which could appropriately reduce

their legal liability when serving teens. As a result, most clinics adopt policies towards teens which are needlessly cautious--and therefore needlessly restrictive to teenagers' access to services.

B. Federal Policies

40. Teenage clients are especially susceptible to changes in federal funding policies affecting family planning services, since most teenagers seeking contraception from a clinic go to clinics receiving federal support.

Based on a survey of all major health care providers in the study sample,* the study team found that all the programs which served teens in any substantial numbers were those that received public funds--either Title V (MCH) or Title X money. Based on this survey, it appears that young teens are not attracted to alternative health care providers such as "free" clinics or women's clinics. Further, health care providers who do not set up a special family planning program do not attract many teen patients. If a teenager is going to go to a clinic for contraceptive care (rather than to a private doctor or a drugstore) she will usually go to an organized family planning program--and in most cases, such a program receives public funding.

Since its enactment in 1970, Title X has been the main source of support for organized family planning services. In recent years, however, the philosophy at the federal level has been to de-emphasize the use of public funds for all categories of services, such as family planning, and maternal and child health. Emphasis has shifted to new approaches: providing set blocks of funds to be used at the discretion of local governments, such as revenue-sharing monies; supporting health service payments through the use of third-party mechanisms; and requiring payment for services from those persons who can afford to pay. The rationale behind the move to third-party payments and direct fees is the belief that many people are receiving public services who are eligible for third-party payment of the service or who can themselves afford to pay directly for services. The result

*Except for New York and Chicago, where size prevented an exhaustive survey, the team talked to local resources such as the regional DHEW offices and local family planning program staffs to ascertain the number of teens served by various health care providers. Included were hospitals, both community and proprietary, neighborhood health centers and other special health programs.

of these beliefs and philosophies at the federal level is that federal appropriations for Title X have remained at the same level for the past three years. Providers at the clinic level have been encouraged to develop fee schedules and payment systems, and to apply for certification as Medicaid providers.

These trends have left many clinics and agencies cynical and disillusioned over the federal government's commitment to support services. Some providers said they wished they had never initiated public funding for their programs; many feel insecure about the future of their activities, and were understandably conservative in mounting any new efforts to attract more patients. As one provider stated, "I can barely serve the patients I have now." When asked how their programs could be improved, the majority of providers said, "More money."

41. Increased dependence of providers on patient fees and third party payments may serve to bar many teenagers from family planning clinics: those who can't afford to pay fees; those who are not able to qualify for third-party reimbursements; and those who can't use their families' third-party reimbursement benefits without revealing to their parents that they are sexually active.

The special circumstances of teenagers' lives which hinder them from paying patient fees--lack of their own money, and an unwillingness to ask their parents either for money or for the information required to qualify for free or low-cost care--have already been discussed in this report. In addition, the trend toward greater reliance on third-party reimbursement puts a special burden on teenagers who need services but who do not qualify for third-party reimbursements--the near-poor, lower middle-class and even middle-class teens who do not have money of their own. Furthermore, relying on third-party payments discriminates against teens who do not want to use their families' third-party reimbursement benefits for reasons of confidentiality.

42. There is a danger that the more cost-conscious providers are forced to become, the greater the likelihood that they will eliminate just the services and procedures teenagers find especially appealing.

Many providers in this study rate personalized service generally and special staff for teenage patients in particular as expensive luxury services, along with patient orientation, education, counseling and community outreach activities. Presumably, therefore, these services would be among the first to go in any belt-tightening--yet

they are precisely the kinds of services teenagers benefit from most. While depersonalizing service for special subgroups of patients would in theory seem to increase efficiency and therefore reduce cost, the study team believes that clinics' attempts at efficiency so far have produced widespread dissatisfaction among patients and staff.

The attempts to divide functions among clinic personnel in clinics where a physician serves as the clinician illustrates the failure. On the assumption that a physician's time is expensive and should not be wasted in duties which other less highly paid employees can perform, the doctor conducts only the exam itself, leaving other staff to perform medical history-taking, lab tests, and education--usually one function per staff member. The results of this staffing pattern are that the doctor feels rushed to hurry through a backlog of waiting patients; the patients are upset over the time spent waiting, the numerous and confusing steps in the process of receiving treatment, and the inability to establish a personal relationship with any staff member; and the staff members, perhaps bored with their narrowly defined jobs, become short-tempered and impatient with patients and each other.

Another possible impact of any future cost-cutting may turn up in lowered criteria for hiring staff members with less attention given to finding personnel interested in and able to work with teenage patients.

43. Title X, while in general easing teen access to clinics, constrains service to teens in two minor ways.

Title X, the Family Planning Services and Population Research Act, is, as described earlier, the largest single source of public funds supporting family planning services. Eighty percent of the programs in the study received such funds. In general the regulations of Title X pose no major problem to serving teens: its flexible eligibility requirements enable clinics to serve the near-poor as well as lower middle-class women. In addition, by providing yearly grants to cover cost of service, it does not force clinics to wait for reimbursement after providing service. In two respects, however, it does constrain service to teens:

- Limiting service strictly to contraceptive service. Some of the programs in the study, by interpreting Title X regulations to mean that they could provide only contraceptive care, do not treat new patients who come for other reasons, such as a pregnancy scare or vaginitis symptoms. Given the fact that so many teenage patients first visit a clinic because they fear they are pregnant, this strict interpretation severely limits the clinics' ability to reach the many teenagers who may be in this situation. Additionally, sexually active teenagers who are not using contraception could be attracted to a clinic if it offered treatment for common vaginitis conditions.

- Inadequacies in data-collection standards. The DHEW reporting system (NCHS) does not break down younger teen patients by age; 18- and 19-olds are grouped together, and those under 18 are in another single category. Most clinics do not keep detailed patient data (by age) of their own, due to a general lack of time and because so much of their staff time is required to fill out the DHEW forms. Given the length of time required for feedback from DHEW, this means that many clinics do not have data on their current patients, nor is the data they do have helpful in planning services for teenagers, since clinics cannot tell from the DHEW reports the extent of their impact on younger teens compared to older teens.

44. Present constraints inherent in Title XIX (Medicaid) illustrate the difficulties of greater future reliance on third party reimbursements.

The study team noted four constraints in Title XIX:

- Eligibility restrictions. Many teens in need of publicly-supported services are not eligible under the Medicaid guidelines. For the most part Medicaid reimburses providers for the medical care of those who qualify for categorical assistance programs such as AFDC, or aid to the disabled. Teenagers per se are not enrolled in these programs unless they have a child and no husband, or parents who are on welfare. Yet many teens who cannot afford to pay are not from welfare families, nor are they unmarried mothers.

- Violations of confidentiality. A teenager in a Medicaid family finds it difficult to use her family's Medicaid card without her parents knowing.

Even when a teenager simply gives the clinic her family's Medicaid card number, it is quite possible (depending on each state's regulations) that a receipt or notice of some kind could be sent to the parents.

- Inadequate reimbursements. As determined by each state, Medicaid reimbursement rates are frequently too low to cover all clinic expenses, since family planning clinics generally receive the lower "clinic" rate rather than the "hospital" rate. Also, the reimbursement rate, originally conceived to cover the cost of a visit to a private physician, does not take into account patient education or counseling--two very important services to teenage patients which are susceptible to cost-cutting, since clinics are likely to eliminate first those services for which they receive no reimbursement.

- Burdensome state regulations. In one study area, the state required that Medicaid patients be given only a three months' supply of oral contraceptives at a time (rather than following the standard procedure of giving a three-month initial supply, then a six months' supply, then, after a check-up one year after the initial visit, permitting patients to return only once a year). This means clinics in this study area are burdened with processing returning patients every three months, a requirement which overloads clinic facilities, causing long waits for patients, and places an undue hardship on patients who must return so often.

45. Title XX (Social Security Act) is not foreseen to be an adequate funding source for family planning services to teenagers.

Title XX supersedes Title IV-A (also of the Social Security Act) and has been initiated so recently that it is difficult to predict how each state will use it. Basically, it reimburses for a range of social services in addition to family planning; how Title XX funds are apportioned among these services is determined by each state.

Title XX is not foreseen to be an adequate source of support for programs for the following reasons:

- Very little Title XX money will probably be allocated for family planning. State officials are aware that other federal funds (Title X) exist to support family planning services; therefore, they may feel that other services deserve a higher priority for state money. Also family planning programs could well be at a disadvantage in competing for funds with child care and other social service programs since child care proponents are well organized and

have powerful lobbies (relative to family planning supporters) in many states. Finally, with the exception of California, New York, and Louisiana, most states do not have a history of using Title IV-A funds (which Title XX replaces) for family planning services. It is therefore assumed that only a minority of the states will allocate substantial Title XX funds to support family planning services.

- Complicated eligibility requirements. Under Title XX guidelines the clinics themselves will have to certify a patient's eligibility. While this procedure is preferable to requiring the patient to report to the welfare office before her clinic visit (as is the case with Medicaid), it puts an added burden on clinic staff. At present, certification requirements are rather elaborate: patient income must be documented by paycheck stubs or a letter from the employer. This procedure not only increases a clinic's expenses in extra staff, it also puts the patient's desire for confidentiality in greater jeopardy. Also, as discussed earlier in this report, it is almost impossible to determine a teenager's family income without violating her desire to keep her clinic visit confidential.

C. Community Attitudes

46. Community attitudes toward premarital sex and birth control for teenagers are ambivalent and moralistic.

Many people, especially older adults, disapprove of premarital intercourse for teenagers. In polls conducted in 1972 (Gallup) and 1975 (NBC-TV), the majority of respondents, and especially those over thirty, felt that premarital sex was unacceptable for teenagers--even though those in the 1972 poll who disapproved of teenage sexual activity were in favor of making birth control services available if they were needed.

While the study team did not directly collect data on community attitudes on these issues, its interviews with family planning personnel indicate that, as far as the providers are concerned, a lack of acceptance of teen sexuality and disapproval of teen birth control services are the prevailing attitudes in their communities. These attitudes also reflect a great deal of ambivalence. While people admit the benefits to teens (and to society) in preventing unwanted pregnancies, there is also a strong punitive undercurrent of opinion which wishes to keep the possibility of pregnancy as a deterrent

to sex. "We may have lost the battle to uphold teenage morality," goes this attitude, "but we're not about to go out of our way to make sex easier for them."

By having sex, teenagers are practicing a different morality than the society at large (made up of adults who generally subscribe to the moral code they were raised with which forbade sex before or outside marriage). Consequently, teenagers face the disapproval of adults, sometimes spoken, but usually unspoken. This fact subtly affects teenagers' behavior in having sex and using contraception. But more importantly for this report, the providers of birth control services to teenagers are affected by these attitudes.

47. Community pressure (real and perceived) against birth control for teens, together with providers' ignorance or confusion over the strength of their legal position, results in frequent efforts to downplay service to teenagers.

Many clinics and agencies take pains to maintain a low profile in order not to attract public attention to the fact that they serve teenagers. They are frequently so successful that teens themselves are unaware of the services. Perhaps the best example of this posture is the very term "family planning center," a euphemism that, while it may allay community fears, says little to the teenager looking for birth control. Planning a family is exactly what most teens do not want to do.

In some cases, fears of negative public reaction, especially from parents, are realistic. A few agencies reported having been picketed, and some parents have filed malpractice suits against clinics, although the study team was unaware of any successful prosecutions. In general, it is the providers' fear of losing community good will and support that causes them to soft-pedal their services to teenagers.

One of the main effects of negative community pressure are in the refusal of other public agencies to cooperate to any great extent in extending family planning services to teenagers:

- Schools. If providers seek to reach teens, it is important for them to gain some access to the school system. Schools are the centers of most teenagers' lives and are perfect locations for outreach activities--yet

many school boards, school administrators and teachers are particularly wary of appearing to encourage birth control by permitting speakers in their schools. The study team observed a wide variety of practices by the schools towards family planning: in one large metropolitan area the board explicitly forbade anyone from a family planning agency to speak at their schools. In another community the local health department received permission to station a full-time outreach worker in the community's two high schools, and as a result almost every "non-user" teen interviewed in this community knew of the clinic. One school had a clinic on its premises. In still another case, the family planning agency's outreach worker was allowed to conduct an on-going "rap" session in a girls' high school.

- Public health departments and county hospitals are also sensitive to conservative public attitudes. A mayor in one study area, wishing to retain his popularity with conservative voters, restricted various city departments' use of publicity to make their teen services known. In a rare instance of cooperation observed by the study team, a city council granted local revenue-sharing funds to support a teen birth control program. This kind of public support, however, was rarely encountered in this study.

The formation of well organized vocal groups against abortion, such as the Right to Life movement, has also increased the wariness of family planning agencies. In one community, for example, the Right to Life movement demands equal time whenever a family planning worker makes a presentation in a local high school--even though abortion is not part of the presentation.

CHAPTER 3. RECOMMENDATIONS

I. RECOMMENDATIONS FOR FEDERAL ACTION

1. *It is recommended that DHEW designate sexually active youths under the age of 18 as a high priority target group for family planning services.*

   Unless DHEW establishes youth under 18 years old as a national priority and acts to support that priority programmatically it is unlikely that the number of teenagers served by organized family planning programs will be increased substantially.

   In addition, DHEW should consider expanding its concern to include all sexually active youth under age 18. The youngest patient encountered in the course of the study was 12 years old. Some clinics, however, reported that they have served sexually active youth as young as 10 years old. By focusing only on "teenagers," many pre-teenage youth will be neglected or deprived of contraceptive protection.

2. *It is recommended that DHEW provide more financial support to teen services.*

   The study team feels that the changes needed at the clinic level will not come about unless more money is available to support special teenage services. Third party payments and private contributions--in the form of both fees and donations--are inadequate sources of support for organized family planning programs. In fact, putting the burden of support onto these sources effectively discriminates against serving young teenagers.

   In addition, numerous changes will have to be made in the organization of present services. Without additional monies, many providers will not be willing or able to institute these changes and continue to operate.

3. *It is recommended that DHEW actively encourage revisions of state laws, policies, or regulations that limit the ability of teenage patients to consent to their own care.*

   The DHEW Regional Offices should encourage and support efforts by providers and regulatory agencies such as state Departments of Health and Welfare to work to eliminate restrictions wherever they may exist which inhibit teenage patients'

ability to consent to their own care. In some states these efforts will require the passage of new legislation. In others, departmental policies at the level of state Departments of Health and Welfare will need to be changed. Most states have legislation permitting the treatment of minors for venereal disease without parental consent. An effort should be made to expand these provisions to include the offering of birth control services. These efforts should be coordinated at the federal level and a national strategy should be developed to work towards these changes. DHEW's previous experiences in encouraging the development of policies which enabled teenagers to consent to their own VD care may provide a useful precedent. Given the current national attention and concern in the news media about the "epidemic" of pregnancies to teenage women, it seems timely for DHEW to act on this matter.

4. *It is recommended that DHEW sponsor a nationwide public information campaign.*

A nationwide public information campaign designed to acquaint the American people with the personal and social consequences of teenage pregnancy and to develop support for the provision of family planning services to teenagers could do much to create a climate where providers would feel more free--and be more able--to actively recruit teenage patients. In addition, it would encourage teenagers who might otherwise be reticent to seek services.

Past experience with the national VD campaign also should be helpful in designing an effective national effort.

5. *It is recommended that DHEW revise the national patient data reporting system to differentiate among various groups of teenage patients; and encourage regional reporting systems to do the same.*

The NCHS system should revise its reporting system to include several differentiated age groupings for the under 18 year olds. For example, patients might be grouped as follows: 10-12 years, 13-14 years, 15-16 years, and 17-18 years old. DHEW also should encourage regional data systems to revise their age categories and to conform to whatever national age grouping system is adopted.

6. *It is recommended that DHEW develop a three-part training and technical assistance strategy to help providers develop effective programs for teenagers.*

Providers will need considerable assistance in dealing with the legal and medical issues involved in serving teenagers and in learning how to design and operate effective family planning programs for teenagers. DHEW's strategy for providing such assistance should include:

- The development of indirect technical assistance materials on various aspects of program design or clinic operation. Appropriate materials might include filmstrips, slide shows, films, or "how to do it" manuals.
- The identification--or development--of "exemplary" projects that can demonstrate particularly successful approaches to serving teenage patients. This strategy has now been used successfully by several federal agencies. The best of such projects might become regional training and demonstration centers.
- The provision of on-site participatory training and technical assistance for the staff, administrators, and/or clinicians of a particular program or clinic.

7. *It is recommended that DHEW further clarify the Title X medical service guidelines, and act to ensure that providers understand and comply with these guidelines.*

In this study providers in different regions varied in their interpretation of the Title X medical guidelines. One area of confusion concerned laboratory testing. Specifically, not all providers felt that VDRL screening (for syphilis) was required under the Title X guidelines. Furthermore, many providers were confused about what clinic services they could offer at an initial visit. For example, young women calling for pregnancy testing who were not already clinic patients were turned away. Similarly, potential patients requesting vaginitis treatment were also turned away.

It is strongly suggested that the guidelines be revised to permit and encourage clinics to provide pregnancy testing and vaginitis treatment not only to their present birth control patients but also to potential patients. The offering of these screening techniques is an effective way to recruit new birth control patients among the teenage population.

Programs also should not be discouraged from engaging in abortion counseling and referral if they have other sources of funding to support these activities.

Since past attempts to clarify Title X guidelines by issuing written materials have only had limited success, it might be well to include the subject of Title X guidelines as a formal training topic in Regional training programs.

In addition, DHEW needs to develop procedures for monitoring compliance with the guidelines on a regular basis.

8. *It is recommended that DHEW encourage providers to make better use of their staff and increase their use of volunteers, non-medical personnel and non-M.D. clinicians.*

Many clinics are using more highly specialized and costly staff than is necessary to provide quality care. In a number of programs, volunteers and non-medical personnel are skillfully conducting clinic functions such as individual patient education, group educational sessions, patient counseling, and simple laboratory procedures which traditionally have been performed only by certain types of professionals.

In other cases, clinics are using nurse practitioners, nurse midwives, and family planning specialists to perform the functions traditionally assigned to physicians.

A program that increases it reliance on less specialized staff benefits in several ways. First, the cost of providing the services can be significantly decreased. Second, many teenage patients prefer being examined by a female clinician and women predominate in the allied health professions. Third, the provider can exercise greater control over policies regarding clinicians and sensitive issues such as the provision of services without consent. If nurses and family planning specialists could be recruited there would be a larger group from which to hire, enabling providers to choose clinicians who feel comfortable about serving teenagers.

However, nurses and family planning specialists are still not approved for licensing in many states. DHEW can play a significant role in encouraging the development of appropriate licensing procedures in those states.

9. *It is recommended that DHEW continue to encourage and provide support for further research in several areas, including contraceptive technology, DES screening, education and counseling, and breast cancer screening.*

   - Further technical research is needed to evaluate the effects of present birth control methods on young patients and to explore the development of new contraceptive methods appropriate for young women.
   - Further research is needed around the efficacy of present DES screening techniques, in particular those simple techniques which clinics could incorporate into their regular patient screening. This research needs to be conducted immediately, so that potential "DES daughters" can be identified among the population of young women presently attending clinics, if appropriate.
   - Further research is needed around the issues of education and counseling, and their relationship to effective birth control use. Providers currently have no body of research to inform them about the best ways to promote effective contraceptive use.
   - Further research is needed on the appropriateness of breast cancer screening among teenagers. This procedure is presently routinely practiced on all teen patients, but indications exist suggesting that such screening may not be warranted among these very young women. Further study is needed to compile already existing information on the incidence of breast cancer among young women, and to survey researchers and cancer experts in order to develop standard practices concerning such screening for teenagers.

II. RECOMMENDATIONS FOR ACTION AT THE CLINIC LEVEL

1. *It is recommended that family planning providers establish a separate teen service.*

The provider's ability to organize an accessible and satisfying service for the teenage client is enhanced if the teen service is separate from regular adult services. The rationale for setting up a separate teen service is not based on teen preferences, for only young teenage clients actually state a strong preference for a separate service. However, a separate teen service increases the provider's

efficiency in providing those service features which teenagers do prefer and require. With the establishment of a separate teen service the provider can identify and train staff who would comprise a special teen-oriented team, can implement convenient teen clinic hours, appointment systems, teen-oriented education and counseling activities and fee schedules and can better provide the confidentiality teenagers desire.

2. *It is recommended that family planning providers increase the initial accessibility of their services to teenagers in the following areas:*

- Parental consent and confidentiality: In order to attract and serve teenagers in any substantial number, providers need to offer services that are confidential and do not require parental consent in any manner or form. Providers should establish clinic protocols which spell out the ways in which the confidentiality of the teenager's visit is insured. This includes establishing confidential methods of keeping in touch with the teen patient (communicating the results of laboratory tests or reminders of next patient visit and the billing of the patient fee, if any). Additionally, providers need to allay teenagers' fears by explicitly telling teenage patients those features of clinic operations which guarantee confidentiality.

- Community education and outreach: As with adult patients, teenagers hear about a service primarily through "word of mouth" sources. However, the information received from these sources may be insufficient or inadequate. Thus, many teenagers in this study initially assumed that a family planning service was for adult or married women, i.e., women who were indeed planning families, and not for single teenagers who wished to prevent pregnancy.

  Providers, therefore, need to communicate their existence to the teen population and the fact that their service is available to teenagers. The key elements of outreach communications should explicitly state:

  --that birth control and related services are available (the term "family planning" should not be used in teen outreach);

  --that the service is for teenagers, not only adult women; and

  --that the service is confidential and parental consent is not required.

- Location of clinic facility: A crucial element of teenage utilization of services is the location of the clinic. It must be conveniently located but at the same time provide sufficient anonymity of the patient visit. Providers should re-examine their present location and determine:

  --if teenagers can be seen entering the clinic facility by other teenagers who may be in the vicinity; and

  --if so, is it obvious to any onlookers that the teen is entering a birth control or other sex-related service (such as VD treatment or maternal and child health care).

  Although the size of the community will affect the strength of this factor in inhibiting teen utilization of services, the lack of anonymity of the teenager's visit may severely jeopardize the clinic's ability to attract and serve large numbers of teens, particularly teenagers under 15 years of age and Latina, Chicana or Asian teens.

  Clinics that cannot offer the anonymity that teenagers value so highly should consider moving or establishing an appropriately situated satellite clinic.

- Fees and payment plans: Providers should offer free services to teenage clients, since the average teenager has little access to money for family planning, either money of her own or her parents' (especially if she wants to keep her sexual activity from her parents). If providers must charge patient fees, teenage clients should not be expected to pay more than $5.00 at one time. Providers must institute a deferred payment system that provides a real option to the teen client to pay fees in small amounts over a period of time. Many clinics have established a so-called deferred payment system, but the URSA research team observed that discussions about fees were in most cases biased in such a way that a real option to pay later or over time did not exist. In situations where teens were truly allowed the option to pay later, many providers were surprised and gratified to see that teen patients usually paid their fees when they were able.

- Appointment system: Teenagers should not have to wait more than one week and preferably less for a clinic appointment. Long appointment waits

contribute to a high patient "no show" rate and severely limit the teen's access to the service. Additionally, providers should experiment more with a staggered appointment system rather than the usual system of requiring numerous patients to attend the clinic at the same time. Staggering patient visits increases efficiency in handling large groups of patients, with the result that the individual patient will spend less time in the clinic. Providers that have instituted staggered appointment systems with teenage clients reported that by and large teens kept their appointments and were highly appreciative of fast clinic processing.

- Hours of the clinic session: Weekday after-school hours, 3-5 p.m., are the most convenient time of day for the average teenager to attend a clinic. In the morning and early afternoon, most teens are in school, and do not wish to inform teachers or school nurses of necessary clinic visits. The teenager's evening hours are usually accountable to parents. Thus, clinics should hold their teen service clinic session between the after-school and dinner hours. Weekend clinic sessions also do not seem to be convenient for teens.

- Pregnancy screening: Providers wishing to attract large numbers of teenagers should provide highly accessible pregnancy testing services to this age group. A pregnancy scare is in many cases a prime motivation for a teenager to attend a clinic facility. Providers should not turn away or make a referral if the teenager only requests a pregnancy test and does not initially want birth control assistance. The results of many teens' tests are negative, providing an excellent opportunity for a discussion of pregnancy prevention. Of course, providers must be trained to handle positive pregnancy test results and be prepared to assist patients in reviewing their options if they are pregnant.

- Signs and directions to clinics: Many clinics situated in a larger facility, such as a hospital or health department, were frequently extremely difficult to find for a newcomer. Providers need to look at the directions to their clinic location from the point of view of a newcomer. Easily read signs need to be posted, preferably using the words "birth control" rather than "family planning," and with clear directions on how to find the clinic.

- Admission to the clinic: Providers should allow exceptions for teenage family planning patients so that teenagers are not required to go through lengthy admissions procedures which the larger sponsoring agency (such as a hospital) may require. Additionally, teenagers should not be required to make two visits to receive services. Some clinics require teenage patients to go through an extensive education or counseling session on a first visit and return a second time for the medical exam. From observing the care provided by many clinics which do not have this policy, the URSA team feels that this procedure is not a necessary prerequisite for quality care, and that it creates an unnecessary hardship and barrier for the teen patient.

3. *It is recommended that family planning providers encourage continuing access of the service to teenagers and provide for high teen patient satisfaction of service by instituting the following measures:*

a. Providers must employ special staff (and special clinicians--discussed in 3b) to serve the teenage client.

- The teen service staff--whether recruited from within the agency or from without (if necessary)--must be selected according to the following criteria:

  --a voluntary willingness and desire to serve teenagers;

  --some level of acceptance of teenage sexuality, a willingness to become more accepting of teenage sexual behavior and an ability to be comfortable in discussing sexuality;

  --sensitivity to and awareness of the special life conditions of teenagers and a tolerance for normal adolescent behavior; and

  --a willingness to establish personal rapport with teen clients and an ability to feel comfortable with the personal demands some teens will communicate.

- Criteria for selection of the teen service staff which are not important are the following:

  --age, dress or "hipness." The quality of the staff interaction is more important to teenage clients than the age or dress of the staff.

  --professional degrees. Again, the degree to which the staff establishes rapport and an accepting environment for teenagers is more important than sophisticated professional training. Non-professional staff and volunteers in the study were observed to operate effectively with teenagers.

- The family planning provider must allow for continuing in-service training of the teen service staff. This in-service training should provide for on-going discussion of the numerous problems and issues encountered in serving the teen patient. In addition, since the staff's feelings and opinions tend to be highly "activated" by teenage patients, emphasis should be placed on helping staff to become aware of and to deal with such feelings during the training.

  Particularly pertinent training topics include:

  --How to deal with teenagers in an age-appropriate manner; how to handle dependency or the very personal demands teens will put on staff; how to eliminate patronizing and over-protective staff behaviors;

  --How to provide effective birth control counseling; how to use the decision-making model and how staff prejudices around particular methods affect the counseling they provide;

  --How to provide effective counseling for pregnant teenagers; how to divert staff frustration at seemingly irresponsible teen behavior in this area; and how to offer nonjudgmental assistance to patients in their decision-making;

  --How to deal with teenage sexuality and with the questions and concerns teenagers communicate to staff in the area of sexual activity; and

  --Innovations in the technology of birth control, and its use by and effects on young adolescents.

b. Providers should assign special clinicians to practice in the teen service session.

It is strongly recommended that the clinician participate as a full member of the teen service team, and participate in on-going in-service training. Providers should not utilize hourly clinicians or clinicians who rotate through the teen service as one of their many duties unless they are provided the extensive orientation and on-going training necessary for the clinician to be effective in serving teenagers. From the URSA team's observations, rotating or hourly clinicians employed in clinics in the study lacked the time and interest required for such preparation. Except for special circumstances, URSA feels that the teen clinician must participate as a full member of the teen service team.

- Criteria for selecting the teen clinician are the following:

  --a voluntary willingness and desire to serve teenagers;

  --some level of acceptance of teenage sexuality, a willingness to become more accepting and an ability to be comfortable discussing sexuality;

  --a specific sensitivity to the fears and anxieties of young women concerning the pelvic exam;

  --a familiarity with early adolescent physical and emotional development; and

  --a willingness to establish personal rapport with teen clients.

- Other characteristics of the clinician which are important if the clinic is attempting to serve teenagers under the age of 15 are that the clinician is young, female, and wears a white examining coat.

- The professional status of the clinician, i.e., whether or not the clinician is a physician, midwife, nurse practitioner, or family planning specialist, is unimportant to the majority of teenagers. Additionally, the simultaneous use of two physicians, an OBGYN and a pediatrician, was not seen to substantially improve the quality of care.

c. Providers must rearrange the present organization of their clinical services to increase the efficiency and speed of their teen client processing.

Clinics should:

- Make further use of staggered patient appointments. Education sessions or "raps," if planned, should be held periodically during the session to allow for a more staggered patient flow.

- Increase the number of clinicians practicing in the clinic session. Increased use of nurse practitioners or other paraprofessional clinicians can help to allay the costs.

- Expand the role of other members of the teen service team, such as receptionist, clinic aid or physician assistant, and laboratory assistant to include patient information-giving and orientation activities.

- Increase the use of non-professional volunteers to assist in patient-flow, and patient education duties.

d. Providers should incorporate into their present services additional service features which are required to effectively serve the teenager.

Specifically, providers should:

- Increase efforts at orienting teen patients to the various stages in patient processing, what happens at each stage, the purpose of each step, and how to find each service station. This orientation should be communicated in written form, or on posters, and reinforced in the group discussion or "rap," if there is one.

- Return visit schedules for teen patients should not be more frequent than is medically appropriate. For example, some clinics' policies of requiring teenage patients using contraceptives to return to the clinic every three months for re-supply is medically unwarranted in the majority of cases, and poses a hardship for the average teenager.

- If group educational activities are planned, clinic staff should not lecture to teenage clients. Factual information on the various methods of birth control should be communicated by films or other audio-visuals. Any group meeting should allow for informal discussion and a question-and-answer period rather than a lecture.

- Providers should focus on the physical clinic environment to insure the the waiting room and exam rooms are clean, neat, and orderly.

- Clinic staff should be knowledgeable in clinic processing so that patient flow is orderly and efficient.

4. *It is recommended that providers increase their ability to promote effective contraceptive use by their teenage patients in the following ways:*

- For those teens who wish to include their boyfriends or sexual partners in the clinic experience (primarily the over 15 year olds), providers should encourage their boyfriends' participation. Providers should inform

teen patients that boyfriends are welcome; they should provide male-oriented reading material in the waiting room, and integrate the partner into any clinic activity (the "rap," interview, or pelvic exam) in which the teen patient wishes him to be present.

- Clinic staff should provide factual information about birth control methods using a "decision-making" model; i.e., the advantages and disadvantages of each method should be stressed and information presented in a manner which allows the patients to make an unbiased choice of the appropriate method for her particular situation.

  --Clinic staff should include in any discussion of birth control those methods most commonly used by teens: rhythm, withdrawal, and the condom. These methods should not be depreciated by the clinic staff; their advantages and disadvantages should be presented in an unbiased manner.

  --Providers should increase the amount of birth control counseling provided to the teenager. The counseling session should be an individual one, focusing on the teen's decision to use a particular method, her considerations about the use of her chosen method and alternative methods, the appropriateness of her chosen method to her sexual activity, and her relationship to her sex partner and parents. Clinic staff (including clinician) should not attempt to talk patients out of their chosen method, nor depreciate it unless clear medical contraindications exist which preclude usage.

  --Follow-up of high-risk contraceptors: Providers should identify high-risk contraceptors among their teen clients and focus more staff effort at following these patients' progress over time. If agreeable to the teen patient, staff could periodically telephone or have an outreach worker contact the teen in school to monitor her situation. Additionally, counseling in the clinic during the patient's visit should focus on those factors in her life situation which make it hard for her to continually use contraception.

- *It is recommended that providers improve the general quality of care provided to their teenage clients by:*

- Incorporating screening for potential "DES daughters" in their medical screening. Educational materials should be provided to all teenage clients about DES. Clinic staff should inquire of all teenage clients if they know of their mothers' use of DES; teenagers should be encouraged to ask their mothers about DES usage if they don't know already. Staff could advise the teenager how to ask her mother without mentioning her visit to the clinic if the teenager desires her visit to be kept confidential.

- Improving the interviewing skills of all clinic staff (including the clinician). The majority of Clinic Personnel need to increase their skill in obtaining appropriate and sometimes crucial information from patients. Staff should be knowledgeable in open-ended questioning techniques. Additionally, clinic staff need to allow themselves the time to actually listen to what patients are telling them and to be skillful in picking up crucial data and probing for further information.

- Insuring that standard medical protocols are practiced by all participating clinicians. An important feature of a standard protocol is that a reliable means exists which insures that relevant patient background and history information is communicated among the different clinic staff, particularly between the clinician and medical history taker or counselor.

- Including as part of clinical services the diagnosis and treatment of vaginitis symptoms of their birth control patients and potential birth control patients.

SUMMARY

Teenagers are more in need of family planning services than ever before, and at increasingly younger ages. Yet many teens do not know of the existence of contraceptive services available to them, or find out only after their first pregnancy. Family planning services generally are not designed to serve the special needs of teenagers--needs for preservation of anonymity and confidentiality, low cost, sensitive treatment, and flexible scheduling--and will need to make substantial changes in their operations if they are to do so. Changes are also needed at the federal and state levels to increase available funding, to change state and local legal restrictions in serving teenagers without parental consent, to alter state regulations concerning the functioning of nurses and family planning specialists, and to provide more technical assistance to local clinics. However, many of the changes at the local clinic level could be initiated without federal support, given an interest and motivation to serve teenagers.

APPENDICES

APPENDIX I

TEEN CONSUMER QUESTIONNAIRES

A. Teen Consumer

B. Teen "Non-User"

C. Male Consumer

APPENDIX I-A

TEEN CONSUMER QUESTIONNAIRE

FAMILY PLANNING SERVICE QUESTIONNAIRE

We are talking to people in this clinic today to try to improve family planning services for teenagers. Your answers will help us to understand better what teens want and need so that we can tell clinics how to improve their service to young people.

PLEASE DO NOT SIGN YOUR NAME. We do not want to know your name. You can feel free to give us your honest opinion, for we will not be able to match your answers to you personally.

You do not have to fill out the questionnaire; fill it out only if you want to. Also, if some questions feel too private for you to answer, feel free to skip those particular questions. If you decide not to fill out the questionnaire, nothing will happen.

We do appreciate your help, though. Your opinions, ideas and feelings about the service you are getting here today are important to us and to the people who run this clinic. We want to know how we can serve you better. Many thanks for your willingness to give us your ideas and your time.

1. How long have you been a patient at this family planning clinic?

_____I have been a family planning patient here for _____.

_____I am coming here for family planning for the first time.

2. What are you here for today? *(You may check more than one answer.)*

_____birth control and pelvic exam
_____VD test and treatment
_____treatment for vaginal infection
_____pick up birth control supplies only
_____pregnancy test
_____other: *(Explain)*_____

3. Did you have to make an appointment to come today? _____Yes _____No

If yes:

a. How do you feel about the amount of time you had to wait for your appointment?

_____Much too long _____Somewhat too long _____Okay

4. Check all the things that made it hard for you to come to this clinic.

_____Clinic is not open at good times
_____Fear that my parents might find out
_____I had money problems.
_____I was afraid of the pelvic exam.
_____Trouble getting here (transportation).
_____The clinic was far away.
_____Other reasons: *(Explain)*_____
_____Hard to get away from home for so many hours
_____Hard to get out of school to come here.
_____I need child care to come here.
_____I was afraid the pills might hurt my body.

5. Do you have a steady boyfriend? _____Yes _____No _____I'm married.

6. Have you ever had sexual intercourse? _____Yes _____No *(If no, go on to #7.)*

If yes:

a. How old were you when you first had sex? _____
b. Do either of your parents know you're having sex? _____Yes_____No _____I don't know
c. Have you ever been pregnant? _____Yes _____No
How many children do you have now? _____

7. Where are you presently living?

_____with two parents
_____with mother only
_____with father only
_____with a guardian or relative
_____I am not living at home *(Explain)*
_____

8. Do your parents know you use this clinic for family planning?

_____Yes _____No

9. How far did your parents go in school? *(Check the highest grade each of them finished.)*

GRADE	*FATHER*	*MOTHER*
Less than 8th grade		
Some high school		
Finished high school		
Some college		
Finished college or more		
I don't know		

10. Have you or your family been on welfare anytime in the last 3 years? ___Yes ___No

11. What is your age? _____

12. What is your race (black, white, etc.)? _____

13. If you saw a doctor today, please answer these questions:

a. Was this the first pelvic exam you've ever had?_____Yes _____No

b. The doctor was a: _____man _____woman

c. _____I liked my doctor very much.

_____The doctor was okay.

_____I didn't like the doctor very much.

14. How do you usually feel about getting a pelvic examination? *(If you've never had a pelvic exam, how do you think you'd feel?)*

_____ It's very embarrassing.

_____It's kind of embarrassing.

_____It's not embarrassing.

15. What did you think of each of these?

	Excellent	Good	Fair	Poor
The people who work in this clinic.				
The medical care you got here.				
The clinic in general.				

16. How do you feel about the amount of time you spent at the clinic today?

_____Okay _____Somewhat too long _____Much too long

17. What did you like BEST about this clinic?_____

_____

_____

18. What did you like LEAST about this clinic? _____

_____

_____

19. IF WE COULD DESIGN A FAMILY PLANNING CLINIC SPECIALLY SUITED TO YOU, WHAT WOULD IT BE LIKE? *(Check one answer for each question.)*

a. I like a clinic that is...

_____close by, the nearer the better

_____farther away so there's not much chance of running into people I know

_____doesn't matter

b. I'd like a clinic where...

_____I make an appointment to come in

_____I drop in without an appointment

_____doesn't matter

c. I'd like a clinic that...

_____is for teenagers only

_____is for teens and older women

_____doesn't matter

d. I'd like a clinic that...

_____encourages guys to come to the clinic with their girlfriends

_____is for females only

_____doesn't matter

e. If my name is called in the waiting room, I'd like to be called...

_____by my first name only

_____by my last name only

_____doesn't matter

f. I'd like to learn about birth control in...

_____a group session

_____an individual session

_____doesn't matter

g. If there is a group session, I'd like it to be...

_____on a different day from when I get my exam

_____the same day as my exam, even if it means a longer wait at the clinic

_____doesn't matter

h. If there is a group session, I'd like it to be...

_____a "rap" session where I can ask questions and talk about birth control with other teens

_____a lecture where I listen to a person tell me about birth control methods

_____doesn't matter

i. I would like a clinic where...

_____someone gives me a chance to talk abou my relationship with my boyfriend or my personal feelings about having sex

_____nobody asks me anything about my relationship with my boyfriend or my personal feelings about having sex

_____doesn't matter

j. I'd rather be examined by a...

_____female doctor

_____male doctor

_____doesn't matter

k. I'd like to be examined by...

_____a young doctor

_____an older doctor

_____doesn't matter

l. I'd like the doctor to...

_____wear a white coat

_____wear regular clothes

_____doesn't matter

m. During the pelvic exam, I'd like the doctor to...

_____explain what he/she is doing during the examination

_____just examine me without talking about it

_____doesn't matter

n. I'd like the doctor to...

_____offer me a mirror to look at my vagina and cervix

_____not bring up the subject

_____doesn't matter

20. HOW IMPORTANT TO YOU ARE EACH OF THE FOLLOWING?

I'd like a clinic where...	Very Important	Somewhat Important	Not too Important	Not at all Important
a. It's decorated to appeal to teenagers				
b. I'm able to bring my boyfriend				
c. The staff is warm and accepting of teenagers				
d. I can get service without my parents' knowledge				
e. The clinic seems well organized				
f. The service and supplies are free or inexpensive				
g. The doctor or clinician is gentle and understanding				
h. I can get information on birth control				
i. There's not much chance of running into people I know				
j. There is a woman doctor				
k. I don't have to spend hours waiting				
l. I can get information about sex				
m. Other: _____ _____				

21. Now, Please tell us which <u>three</u> things on the above list are most important to you.
(Copy the <u>letter</u> of your top three choices in the spaces below.)

_____ is <u>most</u> important to me

_____ is 2nd most important to me

_____ is 3rd most important to me

THANK YOU VERY MUCH FOR HELPING US IN OUR STUDY.

APPENDIX I-B

Sample: Teen "Non-User" Questionnaire

FAMILY PLANNING SERVICE QUESTIONNAIRE

We are talking to people in this clinic today to try to improve family planning services for teenagers. Your answers will help us to understand better what teens want and need so that we can tell clinics how to improve their service to young people.

PLEASE DO NOT SIGN YOUR NAME. We do not want to know your name. You can feel free to give us your honest opinion, for we will not be able to match your answers to you personally.

You do not have to fill out the questionnaire; fill it out only if you want to. Also, if some questions feel too private for you to answer, feel free to skip those particular questions. If you decide not to fill out the questionnaire, nothing will happen.

We do appreciate your help, though. Your opinions, ideas and feelings about the service you are getting here today are important to us and to the people who run this clinic. We want to know how we can serve you better. Many thanks for your willingness to give us your ideas and your time.

1. Have you ever been to a clinic, hospital or private doctor for birth control?

_____Yes _____No

If yes: where did you go? ___Private doctor ___Hospital
___Clinic ___Other (*Explain*);_____

2. Did any of the following things make it hard for you or kept you from going to a birth control clinic? *(Check all things that apply to you.)*

___clinic is not open at the right time
___fear that my parents might find out
___I had money problems
___I was afraid of the pelvic exam
___trouble getting there (transportation)
___the clinic was far away
___hard to get away from home for so many hours
___hard to get out of school to go there
___I was afraid the pills might hurt my body
___I wanted to be pregnant
___Anything else? What? _____
_____

3. How do you usually feel about getting a pelvic examination?

___It's very embarrassing ___It's kind of embarrassing ___It's not embarrassing

4. What is your marital status? ___Single ___Married ___Other:_____

5. How many times have you been pregnant (including this time)?_____
How many children do you have now?_____

6. How old were you when you first had sex? _____

7. Before you became pregnant, did either of your parents know you were having sex?

___Yes ___No ___I don't know

8. Where are you presently living?

___with two parents
___with mother only
___with father only
___with a guardian or relative
___I am not living at home. *(Explain);*
_____

9. How far did your parents go in school? *(Check the highest grade each of them finished.)*

GRADE	*FATHER*	*MOTHER*
Less than 8th grade		
Some high school		
Finished high school		
Some college		
Finished college or more		
I don't know		

10. Have you or your family been on welfare anytime in the last 3 years? ___Yes ___No

11. What is your age? _____

12. What is your race (black, white, etc.)? _____

10. IF WE COULD DESIGN A FAMILY PLANNING CLINIC SPECIALLY SUITED TO YOU, WHAT WOULD IT BE LIKE? *(Check one answer for each question.)*

a. I like a clinic that is...

_____close by, the nearer the better

_____farther away so there's not much chance of running into people I know

_____doesn't matter

b. I'd like a clinic where...

_____I make an appointment to come in

_____I drop in without an appointment

_____doesn't matter

c. I'd like a clinic that...

_____is for teenagers only

_____is for teens and older women

_____doesn't matter

d. I'd like a clinic that...

_____encourages guys to come to the clinic with their girlfriends

_____is for females only

_____doesn't matter

e. If my name is called in the waiting room, I'd like to be called...

_____by my first name only

_____by my last name only

_____doesn't matter

f. I'd like to learn about birth control in...

_____a group session

_____an individual session

_____doesn't matter

g. If there is a group session, I'd like it to be...

_____on a different day from when I get my exam

_____the same day as my exam, even if it means a longer wait at the clinic

_____doesn't matter

h. If there is a group session, I'd like it to be...

_____a "rap" session where I can ask questions and talk about birth control with other teens

_____a lecture where I listen to a person tell me about birth control methods

_____doesn't matter

i. I would like a clinic where...

_____someone gives me a chance to talk abou my relationship with my boyfriend or my personal feelings about having sex

_____nobody asks me anything about my relationship with my boyfriend or my personal feelings about having sex

_____doesn't matter

j. I'd rather be examined by a...

_____female doctor

_____male doctor

_____doesn't matter

k. I'd like to be examined by...

_____a young doctor

_____an older doctor

_____doesn't matter

l. I'd like the doctor to...

_____wear a white coat

_____wear regular clothes

_____doesn't matter

m. During the pelvic exam, I'd like the doctor to...

_____explain what he/she is doing during the examination

_____just examine me without talking about it

_____doesn't matter

n. I'd like the doctor to...

_____offer me a mirror to look at my vagina and cervix

_____not bring up the subject

_____doesn't matter

11. HOW IMPORTANT TO YOU ARE EACH OF THE FOLLOWING?

I'd like a clinic where...	Very Important	Somewhat Important	Not too Important	Not at all Important
a. It's decorated to appeal to teenagers				
b. I'm able to bring my boyfriend				
c. The staff is warm and accepting of teenagers				
d. I can get service without my parents' knowledge				
e. The clinic seems well organized				
f. The service and supplies are free or inexpensive				
g. The doctor or clinician is gentle and understanding				
h. I can get information on birth control				
i. There's not much chance of running into people I know				
j. There is a woman doctor				
k. I don't have to spend hours waiting				
l. I can get information about sex				
m. Other: _____ _____				

12. Now, Please tell us which <u>three</u> things on the above list are most important to you. *(Copy the <u>letter</u> of your top three choices in the spaces below.)* .

_____ is <u>most</u> important to me

_____ is 2nd most important to me

_____ is 3rd most important to me

THANK YOU VERY MUCH FOR HELPING US IN OUR STUDY.

APPENDIX IC

MALE CONSUMER QUESTIONNAIRE

FAMILY PLANNING SERVICE QUESTIONNAIRE

We are interviewing people in this clinic today as part of a nationwide study to try to improve Family Planning Services to teenagers. Your honest answers will help us to better understand what teens want and need. All of this information is kept confidential.

PLEASE DO NOT SIGN YOUR NAME TO THIS QUESTIONNAIRE!

1. Have you ever been to a family planning clinic before? ___Yes ___No

   If yes: ___this clinic ___other family planning clinic

2. Why did you come to the clinic today? *(Check all that apply.)*

   ___I wanted counseling/medical service/supplies for myself.

   ___I wanted to hear information on birth control, pregnancy, etc.

   ___I wanted to share in the experience of getting birth control.

   ___My girlfriend asked me to come along.

   ___I came to provide transportation for a friend or girlfriend.

   ___other: *(Explain)* _____

3. What did you or your girlfriend come here for? *(Check all that apply.)*

   ___male birth control method (condom)

   ___pelvic exam and female birth control method

   ___pregnancy test and/or counseling

   ___VD test and/or treatment

   ___pre-marital exam

   ___other: *(Explain.)* _____

4. If you came here with your girlfriend, whose idea was it for you to come to the clinic together?

   ___my idea ___her idea ___other: _____

5. If you are here with your girlfriend for a female birth control method, who first brought up the idea of getting a method of birth control?

___I did ___she did ___other:_____

a. How did the clinic staff react to your being here?

___the staff seemed glad I came with my girlfriend

___the staff seemed neutral about it

___the staff seemed uncomfortable about a male being here

b. Did the clinic staff invite you to take part in any of the clinic activities?

___Yes ___No

6. What did you do while you were at the clinic?

___nothing, I just waited for my girlfriend

___I read some literature about family planning

___I sat in on a group educational session or "rap" group

___I sat in on an interview or counseling session

___I watched my girlfriend being examined

___other: *(Explain.)*_____

7. How would you rate this clinic?

	Excellent	Good	Fair	Poor
Clinic staff				
Atmosphere or "vibes" of clinic				
Waiting room conditions (crowding)				
Physical appearance (attractiveness)				
Amount of waiting time				
Other:_____				

8. Are you satisfied with the extent to which you were included in the clinic procedure?

___ completely satisfied

___ I wanted to be included more. *(Explain.)*_____

___ I was included more than I wanted to be. *(Explain.)*_____

_____

9. How comfortable did you feel being in a family planning clinic?

___ completely comfortable

___ somewhat comfortable

___ somewhat uncomfortable

___ uncomfortable

10. If not completely comfortable, what things made you feel this way?

_____

_____

11. What could the clinic be doing to make guys feel more welcome and comfortable here?

_____

_____

12. Do you think guys <u>should</u> be included in family planning clinics? ___Yes ___No

Why?_____

_____

13. Why do you think more guys don't come to family planning clinics?

_____

_____

14. What is your age?_____

15. What is your ethnic group or race?_____

16. What is your marital status? ___Single ___Married ___Other:_____

a. <u>If single</u>, do you have a steady girlfriend? ___Yes ___No

17. Have you ever had sexual intercourse? ___Yes ___No

18. How old were you when you first had sex?___ ___ _____

19. Please check whether or not you, along with your girlfriend(s), have ever used any of the following birth control methods.

METHOD	YES	NO
Rhythm or "safe time"		
Withdrawal or "pulling out"		
Condom or "rubber"		
Foam, jelly, cream (used alone)		
Diaphragm		
IUD		
Pill		
Other:		

20. Which of the following statements describe your feelings or experience with condoms (rubbers).

___I don't know where to get them.
___I feel OK about using them.
___Buying them is embarrassing or difficult.
___I can't afford them.
___I always carry a condom with me.
___I can't feel much when I use them.
___It's embarrassing to put them on.
___It's too much of a hassle to use them.
___It would make it look like I was planning to have sex with the girl.
___Other:___ _____

21. How often have you had sex when neither of you used any method of birth control?

___Never ___A few times (10 or less) ___Quite often (more than 10)

22. What time of the month do you think a girl is <u>most</u> likely to get pregnant?

___Right before her period
___Halfway between one period and the next
___During her period
___Right after her period
___I don't know

THANK YOU VERY MUCH FOR HELPING US IN OUR STUDY. YOUR CONFIDENTIALITY WILL BE RESPECTED, AND YOUR ANSWERS WILL HELP US SERVE OTHER TEENS.

APPENDIX II

ANNOTATED BIBLIOGRAPHY

Selected Materials Concerning Teenagers and Family Planning

ANNOTATED BIBLIOGRAPHY

EVALUATION OF FAMILY PLANNING SERVICES FOR TEENAGERS

HEW CONTRACT: HEW-OS-74-304

I. TEEN SEXUALITY: KNOWLEDGE, ATTITUDES, PRACTICE

American Journal of Public Health. "Medical Services for Sexually Active Teenagers" (Editorial). 63:4, April, 1973.

Excellent article covering the need for sex-related services for teens, various approaches to serving teens, and the lack of sufficient legislative and service provisions to meet the current need. Recommends legislative, service, and educational steps be taken to get information and services to teenagers.

Best, Winfield. "Teensex: How Far Do They Really Go?", mimeo. (Distributed by Planned Parenthood Federation of America, Inc., New York)

Report on the sex attitudes and behavior of young men and women today. Discusses the need for birth control services for high school age women, the importance of communication between teens and their parents, and the trend toward responsible and informed sexual activity among teens.

Brunswick, Ann. "Adolescent Health, Sex, Fertility," AJPH, 61:4, April, 1971.

Personal interview survey (1968-1970) with 463 teens 12-17 years of age, mostly black, lower or lower middle class, in New York City. Survey elicits teen opinions concerning their health, marriage, and fertility goals. Teens ranked first health concerns as: drugs, smoking, drinking, sex (VD and pregnancy), in that order. Teen thoughts on marriage and fertility explored.

Finkel, Madelon and David Finkel. "Sexual and Contraceptive Knowledge, Attitudes, and Behavior of Male Adolescents." Family Planning Perspectives, 7:6, 1975.

A survey of male high school students revealed that half of the sexually active adolescent males had begun having sex by age 13. Contraceptive use was sporadic and knowledge was mostly gained from male friends, influenced only slightly by sex education classes.

Gabrielson, Ira W., Sadja Goldsmith, Leah Potts, Vicki Mathews, and Mary O. Gabrielson. "Adolescent Attitudes Toward Abortion: Effects on Contraceptive Practice," AJPH, 61:4, April, 1971.

Teens who are in favor of abortion as a family planning alternative tend to be more responsible about their own sexuality and therefore better contraceptors.

Goldsmith, Sadja, et al. "Teenagers, Sex and Contraception," Family Planning Perspectives, 4:1, January, 1972.

Study conducted 1969-1970 of contraceptors, abortion patients, and maternity patients to elicit attitudes and knowledge about sex and contraception. Contraceptive patients were more often oriented toward college and careers, felt less pressure to have sex, and generally showed more acceptance of their sexuality than the other groups.

Kantner and Zelnik. "Analysis of the 1971 Data by Socioeconomic Variables," Family Planning Perspectives, 4:4, October, 1972.

Analyzes data from their 1971 study of teenage sexuality (see below) by socio-economic variables for the following: sexual experience, contraceptive usage, methods used as factor in use, method choice and pregnancy, and source of contraception. They conclude that "race differences in intercourse experience are persistent and not readily reducible to differences in social and economic circumstances. That the explanation will turn out to be sociological in nature we have little doubt."

_____. "Sexuality, Contraception, and Pregnancy Among Unwed Females in the U.S., 1971," Commission on Population Growth and the American Future, Westoff and Parke (ed.), Research Reports, Volume 1.

Survey (1971) of unmarried females aged 15-19 to determine sexual, contraceptive, and pregnancy experience. Data inflated to provide national estimates. Data collected on: age at first intercourse, knowledge of onset of fecundity, knowledge of what is fertile time in month, knowledge of contraceptive methods, frequency of intercourse, number of partners, use of contraception, methods widely used, reasons for non-contraception, source of contraception, and pregnancy. This study is recognized as cornerstone research in teen sexuality.

Miller, W.B. "Sexuality, Contraception, and Pregnancy in a High School Population," California Medicine, 119:14-21, August, 1973.

Surveys sexual attitudes and practices among students in two San Francisco Bay Area high schools, from both middle class and lower economic status families. Findings are in agreement with Kantner and Zelnik's 1971 findings about knowledge and experience of high school students.

Offer, Daniel. "Attitudes Toward Sexuality in a Group of 1500 Middle Class Teenagers," Journal of Youth and Adolescence, 1:1, 1972.

Study of 1500 middle class teens from Chicago suburbs and Hobart, Australia, including a Sexual Attitude Scale discussed here. No major differences found between nationalities, nor over the 8-year time span the questionnaire was administered. Significant differences appear between younger and older teens. For example, younger teens more often felt that sex was frightening and thought about sex less than older teens. Concludes that there is no evidence of a sexual revolution among teens.

Osofsky, Howard J. "Adolescent Sexual Behavior: Current Status and Anticipated Trends for the Future," Clinical Obstetrics and Gynecology, 14:2, 1971.

Review of the literature on adolescent sexual behavior. Feels that adolescent sexual activity has not increased significantly since the early part of the century, but that attitudes have now caught up. Predictions include that greater permissiveness will mean more pre-marital intercourse among women and that the quality of relationships and adolescents' desires for self-determination will influence decisions to engage in sexual relationships.

Salisbury, Winfield W. and Frances F. Salisbury. "Youth and the Search for Intimacy." In The New Sexual Revolution, Lester A. Kirkendall and Robert N. Whitehurst (eds.), New York: Charles Scribner's Sons, 1971.

Mainly concerned with older teens' attitudes toward sexuality.

Sklar, June and Beth Berkov. "Teenage Family Formation in Postwar America," Family Planning Perspectives, 6:2, Spring, 1974.

Documents childbearing trends among teenagers, showing that the tendency to marry and bear children young, which persisted throughout the first half of this century and to 1960, has changed since 1960 and into the 1970's. Teen marriage rates and fertility declined during the 60's, while teen illegitimacy began to rise during the second half of the decade. In the early 70's, the availability of legal abortion had a strong impact leading to declines in teen illegitimacy rates during 1970 and 1971. Nevertheless, there has been a marked increase in out-of-wedlock childbearing among teen women of both races.

In offering an explanation for the increase in teen illegitimacy rates, the authors cite social and psychological influences on teen non-use of birth control, seeing lack of access as "probably one reason," but other factors as more important. In addition, they feel that the lessening of sanctions against illegitimate childbearing, and the increased social support system available to unwed parents has made keeping one's child a more acceptable alternative for teens.

Sorenson, Robert C. Adolescent Sexuality in Contemporary America: Personal Values and Sexual Behavior, Ages 13-19. New York: World Publishing Company, 1972.

Detailed description of the sexual attitudes and behavior of teens in the U.S. today, based on a national survey of 411 young men and women age 13-19. The study was conducted by a commercial survey organization, Response Analysis Corporation, using a self-administered questionnaire covering sexual practices, contraception, pregnancy, and ways of dealing with it. Kantner feels the results should not be used to generalize about American teens as a group because of the small sample size and the select group of teens which it depicts.

Thiebaux, H. Jean. "Self-Prescribed Contraceptive Education by the Unwillingly Pregnancy," AJPH, 62:5, May, 1972.

Survey conducted with 125 women receiving pregnancy counseling (for abortion) at a center in Boston, to learn about their knowledge and use of contraception, and to elicit their opinions on the optimum learning situation for this information. Most favored mode of education would develop the total concept of human sexuality, including separation of sexual and reproductive function, in the peer group setting of school or home, and should be presented as naturally as other subject areas at all levels of development.

Vener, Arthur M., Cyrus S. Stewart, and David L. Hager. "The Sexual Behavior of Adolescents in Middle America: Generational and American-British Comparisons," Journal of Marriage and the Family, 34:4, 1972.

Study of sexual behavior among three communities in Michigan, including professional, working class and mixed levels of society. Describes responses to questions dealing with non-intercourse sexual activity as well as intercourse. Finds results for the boys are comparable to those of other studies in 1943 and 1948. For the girls, intercourse is experienced at younger ages than in previous studies, with a greater likelihood of girls having had several partners at an earlier age.

Vener, Arthur M. and Cyrus S. Stewart. "More Teenagers Sexually Active in Michigan Study," Family Planning Perspectives, Vol. 7, #2, March/April 1975.

A comparative survey (1970 and 1973) of sexual activity among teenagers in a white, middle-class, nonmetropolitan Michigan community of about 25,000. In 1970, 16.1% of teenage girls were sexually active; this result was strikingly similar to that of Kantner and Zelnick's 1971 study. In 1973, a sharp increase to 22.4% was noted--especially among younger teens between 14 and 16 years of age.

II. SERVICE PROGRAMS FOR TEENS

Arnold, Charles B. "The Sexual Behavior of Inner City Adolescent Condom Users," The Journal of Sex Research, 8:4, 1972.

Report on interviews held with 134 of the men who participated in the condom distribution program (described below). Found that the majority of those taking advantage of the program had used condoms previously, and 68% almost always used them for birth control. Author comments that the respondents are a very small, non-representative portion of the community studied.

_____ and Betty E. Cogswell. "A Condom Distribution Program for Adolescents: The Findings of a Feasibility Study," American Journal of Public Health, 61:4, 1971.

Describes study making free condoms available to low income inner-city men at 9 neighborhood locations. Men of all ages picked up the condoms, with 18 years being the mean age. Use of condoms among this population increased during the distribution program. Concludes that condoms are an acceptable birth control method to young men and that males are willing to take responsibility for contraception.

California Interagency Council for Family Planning. "Preventing Repeat Pregnancy: Teen Clinic Shows Promising Results," Newsletter, November, 1973.

Report on special medical and counseling services for teenage OB patients at Jefferson Davis Hospital, Houston, consisting of intensive counseling in birth control, dating, childcare, etc. Results show that over a five-year period 75% of teens chose a "medically approved" method of birth control and returned for a first routine post-partum check-up. Lacks information on longitudinal follow-up.

Caplan, Harvey, Moderator. "Roundtable: Contraception for Teenagers," Medical Aspects of Human Sexuality, 6:10, 1972.

Discussion of the author with four teenagers on issues relating to providing contraceptives to minors. Discussants agrees that confidential birth control information and services should be available to teens.

_____. "Teen Rap Session," Advances in Planned Parenthood, VIII, 1973.

Description of rap sessions at Oakland, California Planned Parenthood Teen Clinic. Suggestions for effective rap experiences include: non-clinical, warm atmosphere; non-judgemental attitude and acceptance of teen sexuality on the part of the leader; discussion of a wide range of topics of interest to teens, including masturbation, homosexuality, VD, etc.

Family Planning Digest, American Public Health Association Centennial Meeting.. 2:2, March, 1973.

Report on papers delivered at the November, 1972 APHA meetings. Recommendations include: 1) teen services which provide information/education, informal and accepting atmosphere, comprehensive services; 2) screening and treatment of health problems in addition to birth control; 3) prenatal programs which provide family planning services.

_____, "Teen Family Planning Clinics Meet Urgent Personal, Social Needs." 1:3, May, 1972.

Summary of 1971 Westinghouse report on family planning for teenagers. Reports obstacles to successful clinic functioning including: legal necessity for parental consent, fear of community opposition to visible clinic, lack of funds, problems with publicizing availability of services. Found that the availability of pregnancy and VD testing increases use of clinics.

Furstenberg, Frank, G.S. Masnick, and S. Ricketts. "How Can Family Planning Programs Delay Repeat Teenage Pregnancies," Family Planning Perspectives, 4:3, July, 1972.

Study of special prenatal/post-partum birth control programs for predominantly black youth, 15-17 years old, at Sinai Hospital, Baltimore. Concludes that since 50% of program participants had another pregnancy within a three-year period, encouragement is needed to continue use of birth control, with special attention to sexual activity changes and side effect control.

Gordis, Leon, et al. "Adolescent Pregnancy: A Hospital-Based Program for Primary Prevention," AJPH, 58:5, May, 1968.

Description of first year of operation of the Adolescent Family Life Service, Sinai Hospital, Baltimore--a birth control program for nulliparous teen women served with parental consent. Describes intake procedure, attendance at group discussion sessions, and contraceptive decisions. Of 43 patients receiving contraception, 30 were active at the end of one year (a 30% dropout rate).

_____. "Evaluation of a Program for Preventing Adolescent Pregnancy," New England Journal of Medicine, 282:19, May 7, 1970.

Two-year follow-up of the Adolescent Family Life Service, Sinai Hospital, Baltimore. Of 100 women placed on oral contraception, 50 were actively contracepting one year later despite intensive follow-up efforts.

Hambridge, William. "Teen Clinics," Obstetrics and Gynecology, 43:3, March, 1974.

Description of teen clinic in Detroit, established by Wayne State University Medical School Program, March, 1971. Statistics concerning sexual history and contraceptive usage show average age of patients is 16 with average sexual experience of 13 months. Many (41.5%) patients traveled more than 20 miles to reach the clinic from suburban areas. Dropout rate was only 2.5% over 14 months.

House, Elizabeth, and Sadja Goldsmith. "Planned Parenthood Services for the Young Teenager," Family Planning Perspectives, 4:2, April, 1972.

Survey of teen services offered by 153 Planned Parenthood clinics nationwide. Discussion of what makes some teen clinics successful, stressing the importance of convenient scheduling, informal atmosphere with decor that appeals to teens, and staff accepting of teen sexuality.

Irwin, Theodore. "Birth Control for Teenagers," Sexual Behavior, February, 1972.

Reviews the current need for birth control among young teenage women and describes some programs aimed at this group in some cities (e.g., Sinai Hospital in Baltimore, Planned Parenthood Teen Centers in San Francisco and Denver).

Jekel, James. "Factors Associated with Rapid Subsequent Pregnancies Among School-Age Mothers," AJPH, 63:9, September, 1973.

Fifteen month follow-up of New Haven programs for pregnant teenage girls. Results show that high program participation correlates with low post-partum pregnancy.

Jorgensen, Valerie. "One-Year Contraceptive Follow-up of Adolescent Patients," Am J ObGyn, February 15, 1973.

Reviews an intensive effort with young post-partum teens, beginning contraception five days post-partum. Showed a 38% attrition rate after one year of program operation. Concludes that extensive community and family education are needed.

Klerman, Lorraine V. and James F. Jekel. School-Age Mothers: Problems, Programs, and Policy. The Shoe String Press, Inc., 1973.

Presents the findings of a research project funded by the Maternal and Child Health Service of DHEW to evaluate two teen prenatal programs in Connecticut.

Ktsanes, Virginia, Penelope Ballinger, Lydia Haslam. Final Report: Recruitment and Delivery of Family Planning Services to the Young in Urban Areas. New Orleans: Louisiana Family Planning Program and Louisiana Health and Human Resources Administration, December 31, 1974. Mimeo.

Results of a study designed to compare three methods of recruiting teenage patients to teen clinics in family planning centers in three Louisiana cities. Discussion of the efficacy of each method, with the recommendation that a combination of recruitment methods would probably be most effective. Describes the teen clinics established and their functioning. Several recommendations about "what it takes to make a family planning service for teenagers work" including: dedicated staff; intensive, long-term recruitment of the 15-16 year old group; availability of medical service at the time of the rap; educational and service components for teenage men; and funding that recognizes greater costs-per-patient for this age group.

Lane, Mary E. "Contraception for Adolescents," Family Planning Perspectives, 5:1, Winter, 1973.

Description of the Teen Center at Margaret Sanger Clinic in New York City, with attention to the special needs of teens relative to the available methods of birth control.

Martinez, Angel L. Specialized Service Program for Young People, 18 and Younger: November 1969 - December 1971, Planned Parenthood of New York City, n.d.

Report on the development of teen-oriented education, counseling, and referral program instituted by Planned Parenthood in two New York communities in 1969. Discussion of considerations of staff recruitment and training, locations of the services, and eliciting community involvement in developing the program, with emphasis on non-judgemental attitudes and acceptance of sexuality on the part of the staff as well as a willingness to deal with myths, misinformation and attitudes.

Minkowski, et al. "Family Planning Services for Adolescents and Young Adults," Western Journal of Medicine, 120:2, February, 1974.

Examines Los Angeles Health Department free clinics to discover why young people use the clinics. Finds that "attitudinal climate" is major factor--including non-judgemental attitudes, respect of the patient regardless of lifestyle, and "inviolable confidentiality." Especially interesting description of program attributes (or lack of) and patient characteristics.

Newmark, Margaret C. "A Birth Control Clinic for Young Teenagers," Exchange, 2:2, March/April, 1974.

Description of a New York City hospital-based birth control clinic for teenagers which was established apart from the adult "family planning" clinic. The following aspects are seen as contributing to the clinic's popularity: informal atmosphere, educational approach (rap sessions), respect for confidentiality, sympathetic and non-judgemental staff, and encouragement of partner participation.

Rauh, Joseph L., Lois B. Johnson, and Robert L. Burket. "The Management of Adolescent Pregnancy and Prevention of Repeat Pregnancies," HSMHA Health Reports, 86:1, 1971.

Study at Cincinnati General Hospital comparing three groups of teens: those who had previously had a baby and were attending the Adolescent Clinic for birth control; those who had delivered babies at that hospital before any teen programs were established; and those who were enrolled in a special Adolescent Pre-Natal program. Results for the last two groups concerning the pregnancy experience show that the women in the special adolescent pre-natal program had generally fewer problems during their pregnancy and delivery. Results for the first two groups concerning use of birth control and repeat pregnancy show that those in the special adolescent clinic again did better than those with no special service. At the end of two years, 33% of the first group and 79% of the second had had repeat pregnancies and 9% and 60% respectively had not used contraception.

Robinson, Alice M. "Confidential Health Care for the Teenager," RN, November, 1974.

Describes a medical service for teenagers in Minneapolis which is successfully attracting teenagers for medical care. About 60% seek help for sex-related concerns, primarily contraception, although the clinic provides general medical care as well. The structure is non-hierarchical; the focus is on involving teens with their own medical treatment and health maintenance.

Settlage, Baroff, and Cooper. "Sexual Experience of Younger Teenage Girls Seeking Contraceptive Assistance for the First Time," Family Planning Perspectives, 5:4, Fall, 1973.

Study (1972-1973) of 500 patients 13-17 years old in five varied clinics regarding sexual activity and contraceptive usage. Reinforces Kantner and Zelnik data. Established that teens come for birth control after becoming sexually active, debunking the myth that availability of birth control leads to promiscuity.

III. MEDICAL ASPECTS OF SERVING TEENS; PHYSICIAN ATTITUDES

Burks, J.L. "Contraception for Minors: Report of a Physician Survey," Journal of Reproductive Medicine, 5:4, 1970.

Survey to solicit information from physicians on whether they would provide contraception to an unmarried minor on her request but without parental permission. Findings indicate that the majority would do so under certain circumstances. Concluded that medically supervised contraception is available to many teens who request it.

Marinoff, Stanley C. "Contraception in Adolescents," Pediatric Clinics of North America, 19:3, 1972.

Considerations of the various factors involved in choosing a contraceptive to prescribe for teenagers. Factors to be taken into account include: frequency of sexual activity, physical and emotional development of the teen, and motivation for contraception. Discussion of the advantages and disadvantages of each method for use by teenagers.

Measham, A.R., R.A. Hatcher, and C.B. Arnold. "Physicians and Contraception," Southern Medical Journal, 64:4, 1971.

Report on questionnaire sent to all practicing physicians, regardless of specialty, in a predominantly urban county, asking "Are there circumstances in which you would favor the provision of contraception for an unmarried girl?" Eighty-five percent answered yes, under certain circumstances. An unexpected finding was the extent of physician support for the public family planning clinic, and the proportion (37%) who had referred patients to the clinic.

Minkler, Donald H. "Fertility Regulation for Teenagers," Clinical Obstetrics and Gynecology, 14:2, 1971.

Discusses contraceptive needs of teens in various situations: pre-natal, post-partum, married and unmarried. Feels that all teens need more counseling than other patients. Discusses appropriateness of various contraceptive methods for teens, with special attention to pills and IUDs.

Teenage and Premarital Sexual Counseling, Ortho, 1968.

Survey (1968) of 5,000 GP's and OB/GYN's. Twenty-six percent responded to questionnaires. Results indicated that while physicians are often asked by teenagers about illegitimate pregnancy and VD (especially 15-17 year olds), the majority of the doctors will not provide contraceptive information and prescriptions, even with parental consent.

Wolf, Sanford R. and Elsie L. Ferguson. "The Physician's Influence on the Nonacceptance of Birth Control," Am J ObGyn, 104:5, July 1, 1969.

Data gathered from observation, interviews, and a review of consultation records of a Baltimore inner-city prenatal clinic population (predominantly lower class, 75% black) indicate that physicians are not as sensitive as they should be to birth control patients' fears, superstitutions, and preconceptions of birth control, especially lower-class, poorly educated women.

IV. PSYCHOLOGICAL ASPECTS OF ADOLESCENCE

Committee on Adolescence, Group for the Advancement of Psychiatry. "Adolescent Love and the Role of Coitus." In Normal Adolescence: Its Dynamics and Impact. New York: Charles Scribner's Sons, 1968.

Topics researched include adolescent freedom and sexual growth and experimentation. Reviews the inappropriateness of our society's views on sexually active teens. Asks "Should adolescents, at an appropriate age, be allowed or perhaps even encouraged to engage in sexual intercourse before marriage?...Does such experience foster healthy psychological development and successful adulthood or not?" Answer to this question must depend on the maturity of the individual teen.

Furstenberg, Frank F. "Birth Control Experience Among Pregnant Adolescents: The Process of Unplanned Parenthood." Social Problems, 19:2, 1971.

Describes interviews conducted with prenatal patients and their mothers at Sinai Hospital in Baltimore. Finds that teens are more likely to use birth control if they have discussed it with their mothers and if the mothers are accepting of teen sexual activity. The girl is then more likely to see sexual activity as subject to planning. Also discusses the effect of relationship with boyfriend on contraceptive usage, correlating low frequency of sexual activity with less use of contraception.

Graves, William L. and Barbara Bradshaw. "Early Reconception and Contraceptive Use among Black Teenage Girls after an Illegitimate Birth," in American Journal of Public Health. 65:7, 1975.

Examines social and psychological factors influencing selection and use of contraceptive method following an illegitimate birth. Suggests that choice of method may be influenced by social pressures, but use or discontinuation of method is mainly affected by psychological factors such as degree of passivity.

Medical Aspects of Human Sexuality. "Viewpoints: Why Do Unmarried Women Fail to Use Contraception?" 7:5, 1973.

Discussion among five physicians and a social research professor on why married women fail to use contraceptives. For those who do not use birth control, the following reasons are postulated: lack of information; unavailability of birth control, especially to teens; and unconscious motivations to become pregnant. Discussion of characteristics of good relationships and positive self-image that are helpful in developing motivation to use birth control.

Mitchell, John J. "Some Psychological Dimensions of Adolescent Sexuality," Adolescence, VII:28, 1972.

Discussion of eight psychological factors which are important in adolescence and their possible bearing on adolescent sexual behavior. Factors include need for intimacy, need for belonging, desire for dominance, need to achieve competence and mastery of the environment, and desire for passion and intensity.

Roberts, Robert E., Laurence Abrams, and John R. Finch. "'Delinquent' Sexual Behavior Among Adolescents," Medical Aspects of Human Sexuality, 7:1, 1973.

Presents data indicating that girls are much more often legally punished by placement in jail or other institutions for sexual "offenses" than boys. Feels that girls are terribly discriminated against by the law in this area due to socially accepted double standard of sexual behavior.

V. RESEARCH ON NEED FOR FAMILY PLANNING SERVICES FOR TEENS

Consortium on Early Childbearing and Childrearing. Teenage Childbearing: Extent and Consequences, January, 1973.

Contains charts illustrating various aspects of the problem of teenage pregnancies, including: proportion of women 15-19 who are sexually active, by specific age; proportion of women 15-19 using birth control at last intercourse; proportion of women 15-19 giving birth; and the physical, psychological, educational, economic, and social consequences of early childbearing.

Dryfoos, Joy G. "Women Who Need and Receive Family Planning Services: Estimates at Mid-Decade." Family Planning Perspectives, Vol. 7, #4, July/August 1975.

Studies were made to review the applicability of a previously determined formula designed to calculate the number of U.S. women in need of family planning services. The results of several studies were cited to indicate that: 1) the incidence of sexual activity among unmarried women appears to have increased over the past five years (1970-1975); 2) women tend to start having sex at earlier ages; 3) there had been a 10% increase (from 20%) in sexual behavior among teens aged 15-17; 4) teens were seeking contraceptive help in higher proportions; and 5) illegitimacy and abortion rates were high and increasing for teenagers in the United States.

Some specific studies cited were: a 1971 Johns Hopkins study of teenage sexuality; a Michigan study in 1970-1973; and a 1973 study in San Francisco.

Family Planning Evaluation Project (FPEP) Reports, Department of Maternal and Child Health, School of Public Health, University of North Carolina, Chapel Hill.

#1-71	"Estimating the Need for Contraceptive Services in the Younger Age Groups."
#4-71	"Access to Medical Contraception of Women in Low Income Urban Areas, By Income and Education."
#5-71	"Contraceptive Methods Recently Used by Women in Low Income Census Tracts in 16 U.S. Cities."
#17-72	"The Planning Status of Births to Unmarried Women."
#20-72	"Preliminary Estimate of the Reduction of Prematurity Rates By the Prevention of Unwanted Pregnancies."

Unpublished, informal reports on several aspects of family planning.

Focus on Health #6: Family Planning for Teenagers. Westinghouse Learning Corporation, Health Services Division, 1971.

Reviews in detail the provision of family planning services to teenagers in the United States. Covers all aspects of the issue, including the need for services for teens, the consequences of teen pregnancy and childbearing, and the availability of services for teens. Describes existing programs in several areas of the country, and discusses the problems associated with providing family planning for teens.

Pomeroy, Richard, and Lynn Landman. "Public Opinion Trends: Elective Abortions and Birth Control Services to Teenagers," Family Planning Perspectives, 4:4, October, 1972.

Gallup Polls (1972) show that the vast majority of white Americans of both sexes and all ages favor the availability of birth control services to sexually active teens. Most variables do not affect the results with the exception that higher levels of education usually correlate with greater need perceived. The authors comment that these results refute the myth that communities would oppose birth control clinics for teens, by illustrating that people are in agreement about the need for services, even though they may disapprove of sexual activity among this age group.

Vadies, Gene and Richard Pomeroy. "Out of Wedlock Pregnancy Among American Teenagers," Journal of Clinical Child Psychology, 3:3, Fall/ Winter, 1974.

Reviews the following available national statistics demonstrating need for birth control services for the 15-19 age group in 1973: out of wedlock births (177,000), pregnancy terminations (375,000), early marriage births (110,000), and fetal losses (43,000). Total pregnancy statistics:705,000.

VI. MISCELLANEOUS

Cutright, Phillips. "Illegitimacy: Myths, Causes and Cures," Family Planning Perspectives, January, 1971.

Critical examination of many well-accepted myths about illegitimacy causes and trends. Discards most current mythology as lacking scientific evidence. Suggests current illegitimacy rates increasing because of increased "exposure to risk" and shift of responsibility for birth control from male to female. Sees need for programs and information to be readily available to unmarried women of all races and economic groups.

_____. "The Teenage Sexual Revolution and the Myth of an Abstinent Past," Family Planning Perspectives, 4:1, January, 1972.

Examines whether sexual activity among teens has increased in the last 25 years. Suggests that sexual activity has not increased, although teenage pregnancies have, and cites causes.

Gordon, Sol. The Sexual Adolescent; Communicating with Teenagers About Sex. N. Scituate, Mass.: Duxbury Press, 1973.

Written to help people communicate with adolescents about sex. Discusses why adolescents need to know the facts about various aspects of sex and why they should have access to medical aid and contraceptives. Presents information and statistics on VD, pregnancy, abortion, and family planning services. Discusses religious viewpoints and sex education possibilities.

Menken, Jane. "The Health and Social Consequences of Teenage Childbearing," Family Planning Perspectives, 4:3, July, 1972.

Discussion of teenage fertility rates, mortality risks, and future pregnancy predictions. Teenagers currently account for a greater percentage of childbearing women, though the national birthrate is declining. This proportional increase is due partly to greater numbers of teens in the population and partly to women 20 and older having greater decrease in birthrate during the 1960's. Points out for young mothers both increased risk of infant mortality and rapidity of subsequent pregnancies when first pregnancy occurs at young age.

Osofsky, Howard J. "Sex Education and Contraception." In The Pregnant Teenager, Springfield, Ill.: Charles C. Thomas, Publisher, 1968.

Reviews the right of teens as individuals to make decisions concerning the use of their own bodies. Cites evidence which points to the capacity and ability of teenagers for such decision-making. Discusses the difficulties of teens and especially poor teens in getting birth control (difficulties with welfare department, unsympathetic doctors, time-consuming red tape). Recommends appropriate contraception be made available to anyone who wants it as a method of avoiding unwanted teenage pregnancies.

Perkins, Barbara B. Prevention of Adolescent Pregnancy--A Consideration of Adolescent Sexuality, The Consortium on Early Childbearing and Childrearing, Child Welfare League of America, Inc., Summer, 1974.

Summary of a workshop sponsored by CECC held October 8-9, 1973, to learn how to help adolescents avoid pregnancy. The 39 participants divided into teams and discussed five subject areas: multi-health services, parents, peers, professional education, and schools and communities. The workshop studied availability, success and problems of existing services, and developed ideas and suggestions on new approaches. The many differing opinions which provoked discussion at the workshop are given here.

Selstad, Georgiana M. et. al. "Predicting Contraceptive Use in Postabortion Patients," in American Journal of Public Health, 65:7, 1975.

Identifies factors which are associated with use or non-use of contraception among post-abortion patients. Non-users tend to disapprove of premarital sex, to perceive parents and peers as disapproving of premarital sex, and to share parental attitudes on this subject. Authors suggest that pregnancy counselors explore these significant attitudes and give added attention and support to those women who may be at risk following abortion.

Stokes, Walter R. "Control of Procreation." In The New Sexuality, Herbert A. Otto (ed.), Palo Alto, California: Science and Behavior Books, Inc., 1971.

Discusses sexual freedom and responsibility for teens; need for birth control for teens; need for communication between the generations; and need for society to acknowledge the changing behavior of young people.

Teenage Pregnancy on the Rise, mimeo.

Review of a three-day conference in Racine, Wisconsin, sponsored by the Institute for Family Research and Education, College of Human Development, Syracuse University (Dr. Sol Gordon, Director). The conference brought together 40 leading sex educators to examine the legal, moral, and medical aspects of adolescent sexual behavior, to discuss existing and new approaches in dealing with crisis situations, and to explore new ways to educate teenagers and adults in a deeper understanding of the rights and responsibilities of human sexuality.

VII. SELECTIONS ON TEENAGE PREGNANCY

Consortium on Early Childbearing and Childrearing. A Discussion of State Laws and State and Local Policies as They Relate to Education of Pregnant School-Age Girls. Washington, D.C., 1972.

"Education Key to Less Teenage Pregnancy," Family Planning Digest, 1:2, March, 1972.

Goldstein, Phillip, et al. "Vocational Education: An Unusual Approach to Adolescent Pregnancy," Journal of Reproductive Medicine, 10:2, February, 1973.

Hassan, H. Mohammed, and Frederick H. Falb. "The Young Primipara, A Critical Study," Am J ObGyn, 88:2, January 15, 1964.

Howard, Marion. "Comprehensive Community Programs for the Pregnant Teenager," Clinical Obstetrics and Gynecology, 14:2, June, 1971.

Hulka, Jaroslav F., and John Schaaf. "Obstetrics in Adolescents: A Controlled Study of Deliveries by Mothers 15 Years of Age and Under," Obstetrics and Gynecology, 23:5, May, 1964.

Israel, S. Leon, and Theodore B. Woutersz. "Teenage Obstetrics, A Cooperative Study," Am J ObGyn, 85:5.

National Association of Secondary School Principals. A Legal Memorandum Concerning Student Marriage and Pregnancy. Washington, D.C., 1973.

Osofsky, Howard J. The Pregnant Teenager. Springfield, Ill.: Charles C. Thomas, 1968.

Sarrel, Phillip M., and Lorraine V. Klerman. "The Young Unwed Mother, Obstetric Results of a Program of Comprehensive Care," Am J ObGyn, 105:4, October 15, 1969.

Semmers, James P., and William M. Lammers. Teenage Pregnancy. Springfield, Ill.: Charles C. Thomas, 1968.

Siecus Study Guide No. 14. Teenage Pregnancy: Prevention and Treatment, New York, 1973.

von der Ahe, Clyde V. "The Unwed Teenage Mother," Am J ObGyn, 104:2, May 15, 1969.

VIII. EDUCATIONAL MATERIALS FOR TEENAGERS*

Arkansas Family Planning Council. The BIG Book of Birth Control, Hendrix Hall, P. O. Box 5149, Little Rock, Arkansas 72205.

Basic, sparse information about the various birth control methods. Very simply written, with four or five sentences on each method, easily understood, including drawings of the methods described. For consumers with limited reading skills.

Birth Control Handbook; VD Handbook, P. O. Box 1000, Station G. Montreal 180, Quebec.

Two extremely thorough, well-written, and sophisticated booklets designed to provide all available medical information in depth to lay readers. Provides highly detailed and often technical information on all subjects. The booklets also discuss the social and cultural context of the medical care delivery system in the U. S. and Canada. The introduction to the Birth Control Handbook discusses the issues of birth control versus population control, and the introduction to the VD Handbook encourages the development of a new morality based on "mutual respect and concern" and "responsible love."

Emory University Family Planning Program. True to Life, Robert A. Hatcher, M.D., Director; Box 26069, 80 Butler Street, Atlanta, GA 30303.

Magazine-type format designed to teach facts about sex and birth control in the context of fun and readable "true confessions" style. Accepting of sex within mutually caring relationships. Down-to-earth language and non-judgmental attitudes.

_____. What's Happening. Atlanta, GA

Another magazine for young people, especially appealing to inner-city youth. Discusses many aspects of sex, love, and VD in an open and accepting manner and in down-to-earth language.

* Addresses are provided for those interested in obtaining publications.

Gordon, Sol. Facts About Sex: A Basic Guide, New York, John Day Co. 1970.

Open, straightforward presentation of sexual information in down-to-earth language. Much good information and positive attitudes toward sex, though laced with some moralizing and judgmental statements. Excellent drawings of fetal development and the stages of childbirth.

_____. Ten Heavy Facts About Sex; VD Claptrap; Protect Yourself from Becoming an Unwanted Parent, Ed-U Press, 760 Ostrom Ave., Syracuse, N.Y. 13210.

Three excellent "comics" which present clearly-written factual information about sex, VD, and birth control accompanied by humorous, lively comic-strip drawings that incorporate slang words and myths associated with the subjects. All important information is covered in easily readable language and down-to-earth style. VD Claptrap includes a Spanish version of "Basic Facts about Syphillis and Gonnorhea."

Gray, Marian and Roger. How to Take the Worry Out of Being Close, P.O. Box 2822, Oakland, California 94618.

Excellent discussion of birth control methods and venereal diseases. Drawings of each method as well as reproductive systems. Clearly written and easily understood while presenting thorough information, including advantages and disadvantages of each method.

Johnson, Eric. Love and Sex in Plain Language, Philadelphia, Lippincott, 1973.

Covers reproductive and anatomical facts in more scientific and detailed language than many other books for teens. Reinforces traditional sex-role stereotyping and implies that homosexuality and masturbation may be problems. Good discussion of teen relationships and feelings; strong reasons presented against premarital intercourse.

_____. Sex--Telling It Straight, Philadelphia, Lippincott, 1970.

Good, simply written book for younger teens. Includes glossary of slang terms and covers conception and birth in some detail, as well as anatomy, intercourse, birth control, and the place of sex in life.

_____. V.D., Bantam Books, 1973.

A detailed and scientific presentation of the issues around VD, including many statistics. Though the essential information on VD does not appear until Chapter 5, it is then presented very clearly, with a good step-by-step description of a visit to a public health clinic for a VD check-up.

Neuman, Hans. The Straight Story on VD, New York, N.Y. Warner Public Library, 1973.

Clearly written, thorough information on VD presented in question and answer format. This book could be easily read by teenagers. Presents the basic facts and myths about VD and also covers VD and pregnancy, contraception, douching, and homosexuality.

Planned Parenthood Federation of America, Inc. Birth Control: All the Methods That Work...and the Ones That Don't. 810 Seventh Avenue, New York, N.Y. 10019.

Well written, concise information on all methods of birth control, including side effects, contraindications, and instructions for use. Also a section dispelling myths about methods that don't work, and information on abortion and sterilization.

_____. Sex Alphabet, New York, N.Y.

Excellent, brief factual definitions of terms related to sex and sexuality. Especially good treatments of the decision to have sex, climax, and homosexuality.

Planned Parenthood Center of Syracuse, Inc. Growing Up--'Specially for Pre-Teens and Young Teens; Teen Questions about Sex, and Answers, 1120 Genesee Street, Syracuse, N.Y. 13210.

Two booklets describing sexual development and various aspects of sexuality. The booklet for pre-teens presents and discusses the changes that both girls and boys experience during puberty, in simple, clear language. The second booklet is an excellent, wide-ranging discussion of sexuality, including masturbation, sexual intercourse, birth control methods, VD, abortion, homosexuality, prostitution, drugs, alcohol, etc. It is written with respect for teens' ability to make their own decisions.

Pomeroy, Wardell. Boys and Sex, New York, Delacorte Press, 1968; Girls and Sex, Delacorte Press, 1970.

Two well-written, far-ranging discussions of sex and sexuality. Delves into both the emotional and physical aspects of sex, including dating, petting, intercourse, masturbation, and homosexuality. Stresses the importance of relationships and positive attitudes toward sexuality within relationships that are mutual and caring. Adequate discussions of birth control methods appear in the chapter in each book entitled, "Consequences of Pregnancy."

Rocky Mountain Planned Parenthood. Rocky Mountain Planned Parenthood Publications, 2030 East 20th Ave. Denver, Colorado 80205.

Rocky Mountain Planned Parenthood publishes 10 pamphlets and booklets of varying length and scope on several aspects of sexuality, relationships, gynecological care, and birth control. The booklets are direct and forceful in style and language, designed to get young women and men thinking about honesty, equality, and responsibility in relationships, sexuality, and contraception. In some instances the harshness of the style detracts from the intended message.

U. S. Department of Health, Education, and Welfare. VD and You, Public Health Service.

A brief flyer directed at teenagers, presenting the basic facts about syphillis and gonorrhea in an easily readable format.